Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02300

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6½ Yrs.
Hospital, institution, or street address where death occurred:
761 Fayette St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 761 Fayette St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Celeste Africa

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Samuel B. Africa
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 13, 1869

8. AGE: Years	Months	Days	If less than one day
77	11	24	hrs. min.

9. Birthplace: Mt. Union, Penna. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Samuel Cambell
13. Birthplace: Penna.

MOTHER
14. Maiden name: Adelaide Landis
15. Birthplace: Penna.

16. Informant: Mrs. A. M. Penhallow
Address: 20788 Erie Rd. Rocky River 16, Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 9, 1947 (month) (day) (year)
Cemetery or crematory: HillCrest Burial Park
Location: Cumberland, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. March 9 19 47 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7, 1947 at 9:30P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/7/47 19 to 3/7/47 19
and that I last saw her alive on 3/7/47 19

Immediate cause of death	DURATION
Bronchopneumonia	
Due to: Senility	
Due to: Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. Williams M.D. M. D. or other
Address: Cumberland Md. Date signed: 3/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (139-B)

CERTIFICATE OF DEATH

02301

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 54½ Marion St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Myrtle Alderton

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thomas F. Alderton
6.(c) If alive, give age: yeare

7. Birth date of deceased (mo., day, yr.): Feb. 10 1885

8. AGE: Yeare	Months	Days	If lese than one day
62	1	6	hrs. min.

9. Birthplace: Old Town, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Leonard S. Crabtree
13. Birthplace: Maryland
MOTHER 14. Maiden name: Fannie Meyers
15. Birthplace: Maryland
16. Informant: Mrs. Thelma Streett
Address: 54½ Marion St. Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 19 1947 (month) (day) (year)
Cemetery or crematory: HillCrest Burial Park
Location: Cumberland, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.
19 March 18, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16, 1947, at 5:30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 1947 to March 16 1947 and that I last saw h alive on March 16 1947

Immediate cause of death	DURATION
Paralytic Ileus	
Due to Coronary Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Complete Prolapse Date of op. 3/10/47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. C. Thrush M. D. or other
Address: Cumberland Date signed: 3/18/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

02302 40

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

312 N. Waverly Terrace

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 312 N. Waverly Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME LeRoy Charles Allamong

3.(b) Social Security Number 214-05-9999

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Married

6.(b) Name of husband or wife Hannah Struckman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6 August 1896

8. AGE: Years	Months	Days	If less than one day
50	5	28	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany Co., Md. (Town, county, and state)

10. Usual occupation Store Clerk

11. Industry or business Kelly Springfield Tire Co.

FATHER 12. Name William T. Allamong

13. Birthplace West Virginia.

MOTHER 14. Maiden name Mary Young

15. Birthplace West Virginia

16. Informant Hannah Allamong

Address 312 N. Waverly Terrace, Cumb., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 MAR 1947 (month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19. March 7 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 47, at about 12.40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on Dead March 4 19 47

Immediate cause of death	DURATION
Suffocation & 3rd. degree burns	at once
Due to	
Due to Over heated hot air furnace	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3-4-47

Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) home

Means of injury home burned, also Mr. Allamong Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or other

Address Cumberland, Md. Date signed 3-4-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02303

Reg. Diat. No. 80

1. PLACE OF DEATH:
County: Allegany
City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Paradise Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Paradise Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George B. Allen

3.(b) Social Security Number: 164-10-3094

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Nellie Cavanaugh
6.(c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): Oct 10, 1888

8. AGE: Years: 58 Months: 5 Days: 3 If less than one day: hrs. min.

9. Birthplace: Eckhart, Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Janitor of Kelly-Tice Co.
11. Industry or business: Janitor

FATHER
12. Name: Thomas Allen
13. Birthplace: England

MOTHER
14. Maiden name: Adelia Rattigan
15. Birthplace:

16. Informant: Mrs. George B. Allen
Address: Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 17 47 (month) (day) (year)
Cemetery or crematory: Belvedere Cemetery
Location: Midland, Md.

18. Funeral director: M. J. Eichhorn
Address: Lonaconing, Md.

19. 3/12 (Date rec'd by registrar) 19 47 Jeanette M Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 19 47 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 19 46, to March 13 19 47.
and that I last saw him alive on March 13 19 47

Immediate cause of death	DURATION
Pulmonary tuberculosis	
Due to	
Due to Arteri-Sclerosis	—
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D.
M. D. or other
Address: Frostburg, Md. Date signed: 3/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

02304

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 74 yrs 11 m 23 d
Hospital, institution, or street address where death occurred: 18 E. Front Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 18 E. Front Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Martin Barry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Matilda Edcuna Ross
6.(c) If alive, give age: 4 years

7. Birth date of deceased (mo., day, yr.): May 6, 1872

8. AGE:

Years	Months	Days	If less than one day
74	11	23	hrs. min.

9. Birthplace: Lonaconing, Allegany Co. Md.
(Town, county, and state)
10. Usual occupation: Coal Miner, Retired
11. Industry or business: Jackson Coal Co.
FATHER
12. Name: Patrick Barry
13. Birthplace: England
MOTHER
14. Maiden name: Mary Conly
15. Birthplace: Ireland
16. Informant: Mr. Earl Barry
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 1, 1947 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Lonaconing, Md.
18. Funeral director: M. J. Eichhorn
Address: Lonaconing, Md.
19. April 2 1947 (Date rec'd by registrar) J. Jeanette M. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1947 at 3:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 1947 to March 29 1947
and that I last saw him alive on March 28 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to:	
Due to:	
Other conditions: Chronic Bronchitis & Asthma	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other
Address: Lonaconing, Md. Date signed: March 31st 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A1[illegible]5-15M

1-35

Birth & Death

MARYLAND STATE DEPARTMENT OF HEALTH (140-0)

CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No. 9 02305

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County Allegany
   City or town Frostburg
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: Miners Hospital
   Length of mother's stay in County Life
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State Maryland
   County Allegany
   City or town Lonaconing
   (If outside city or town limits, write RURAL and give nearest town)
   Street No. Rolen Street
   (If RURAL give LOCATION)

3. Name of child Baby Boy Bell
4. Date of birth March 13 1947 Hour 3 00 P.M.
5. Sex Male | 6. Twin or triplet
7. No. of weeks pregnancy 20

FATHER OF CHILD

8. Full name William James Bell
9. Color White 10. Age at time of this birth 27 yrs.
11. Usual occupation Machinist

MOTHER OF CHILD

12. Full maiden name Anna Lee Johnson
13. Color W 14. Age at time of this birth 26 yrs.
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 2
    (b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? no During labor? no
18. Pregnancy, complications of Bleeding during last 7 months of pregnancy
19. Labor: (a) Complications of none
    (b) Induced? no
20. (a) Was there an operation for delivery? no (Yes or No)
    (b) State all operations, if any
    (c) Did child die before operation?
    During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes Prematurity
    (b) Maternal causes Placenta Previa

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
    Signature Hilda Laurel Waltz MD (Specify if M. D., midwife, or other)
    Address Frostburg Md.

23. (a) Burial (Burial, cremation or removal) (b) Date thereof 3-14-47 (month) (day) (year)
    (c) Cemetery or crematory Oak Hill Cem.
24. (a) Funeral director Wm. James Bell
    (b) Address Lonaconing, Md.

25. (a) 3-13-47 (Date rec'd by registrar) (b) Mrs. Nancy N. Roe (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    Health Officer, per

V. S. A10

* See Instruction C on stub.

Child lived 10 minutes expiring at 3 10 PM 3/13/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02306

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Ecknart Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50Yrs.
Hospital, institution, or street address where death occurred:
Eckhart Mines, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Albert Bender

3.(b) Social Security Number: 220-10-4165

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Martha Ella Robinson Bender
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 24th., 1866

8. AGE: Years	Months	Days	If less than one day
80	II	0	hrs. min.

9. Birthplace: Green Ridge, Md. (Town, County, and State)
10. Usual occupation: Retired
11. Industry or business: Celanese Corp.
12. FATHER — Name: Augustus Bender
13. FATHER — Birthplace: Germany
14. MOTHER — Maiden name: Unknown
15. MOTHER — Birthplace: Unknown
16. Informant: Mr. Ralph Bender
Address: 61 Frost Ave. Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-26-1947 (month) (day) (year)
Cemetery or crematory: Eckhart Cemetery
Location: Eckhart, Md.
18. Funeral director: Jacob Hafer
Address: Frostburg, Md.
19. 3-25 1947 (Date rec'd by registrar) Mrs. Nancy V. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 1947 at about 5 A. M.
I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive on March 24 1947
Immediate cause of death: Coronary occlusion — DURATION: at once
Due to: Arterio sclerosis
Due to:
Other conditions: (Found dead in bed)
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
Legally Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H.V. Deming M.D. M. D. or Coroner
Address: Cumberland, Md. Date signed: 3-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

Within corporate limits

W. E. B. Owens

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 92d

★ 02307

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs

Hospital, institution, or street address where death occurred: 209 Race St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 209 Race St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Edward Bishop

3.(b) Social Security Number: 213-22-3274

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Amanda Smith

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Sept 26, 1872

8. AGE: Years: 74 | Months: 6 | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Washington Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: State Road Employee

FATHER — 12. Name: George A. Bishop

FATHER — 13. Birthplace: Pa.

MOTHER — 14. Maiden name: Rebecca Welch

MOTHER — 15. Birthplace: Bedford Co. Pa.

16. Informant: Mrs. Edna E. Bishop

Address: 209 Race St - Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 2, 1947 (month) (day) (year)

Cemetery or crematory: Mt Olive Cemetery

Location: Near Hancock Md

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. April 1, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1947 at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1944 to March 30 1947

and that I last saw h... alive on March 30 1947

Immediate cause of death	DURATION
Valvular Heart disease	3 yrs
Due to: Myocarditis Chronic	Life
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. E. B. Owens M.D. M. D. or other

Address: 33 Va Ave Date signed: 3/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1735

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-a)

CERTIFICATE OF DEATH

02308

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Allegany
City or town: RURAL - CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
NORTH BRANCH
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: (RURAL) Cumberland.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: NORTH BRANCH.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 2

3.(a) FULL NAME: Frank Ellsworth Bloss

3.(b) Social Security Number: 218-11-4445

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 15 1922

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
25	1	27		

9. Birthplace: NORTH BRANCH - ALLEGANY CO. MD (Town, county, and state)
10. Usual occupation: Milling Machine Operator.
11. Industry or business: Glenn Martin. (aeroplane)

FATHER
12. Name: James E. Bloss.
13. Birthplace: N. Branch Md

MOTHER
14. Maiden name: Ethel Amy Emmett
15. Birthplace: W. Va.

16. Informant: Jas Bloss.
Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 16 47 (month) (day) (year)
Cemetery or crematory: Davis Memorial Cem.
Location: Oldtown Rd. Cumberland
18. Funeral director: Louis Stein Jr.
Address: Cumberland.

19. March 16, 19 47 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 19 47 at about 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him Dead March 13 19 47

Immediate cause of death	DURATION
Strangulation & fracture of neck.	at once
Due to: despondency	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of: 3-12-47
Where did injury occur? North Branch (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: hung himself Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H. V. Deming M.D. H. V. Deming Md (M. D. or other)
Address: Cumberland Md Date signed: 3-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

Within corporate limits

DR. FAW

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46d)

CERTIFICATE OF DEATH

02309

Reg. Dist. No. 40

1. PLACE OF DEATH

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 39 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. HILL CREST DRIVE
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME MRS. CORA BROADWATER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife CLARENCE BROADWATER 6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) MARCH 5, 1879

8. AGE: Years	Months	Days	If less than one day
68	0	2	..... hrs. ..... min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name JESSE R. ROBINSON
13. Birthplace MARYLAND

MOTHER 14. Maiden name ELMYRA WILHELM
15. Birthplace MARYLAND

16. Informant Clarence Broadwater
Address Rt. 4, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 9, 1947 (month) (day) (year)

Cemetery or crematory St. Luke's Lutheran Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. March 9, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 7, 1947 at 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 19 47, to Mar 7, 19 47 and that I last saw h.. alive on March 6 19 47

Immediate cause of death	DURATION
(a) Cachexia	
Due to (b) Squamous cell Carcinoma of rectum with generalized	
Due to (c) lymphatic metastasis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Squamous carcinoma of rectum - with lymph. metastasis Date of op. June 30, 1947

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE Wyley M. Faw, Jr. M.D.
M. D. or other

Address 58 Baltimore St. Cumberland, Md. Date signed Mar. 7, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02310

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 Years

Hospital, Institution, or street address where death occurred:

211 Carroll St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 211 Carroll St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edith Freida Bromery

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Randolph Bromery

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 24 1904

8. AGE: Years	Months	Days	If less than one day
43	2	7	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Maryland

(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER — 12. Name: Robert Edmondson

FATHER — 13. Birthplace: Paw Paw, W. Va.

MOTHER — 14. Maiden name: Annie Toliver

MOTHER — 15. Birthplace: Moorefield, W. Va.

16. Informant: Randolph Bromery

Address: 211 Carroll St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/3/47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

19. Funeral director: William H. Kight

Address: Cumberland, Md.

19 April 3 19 47 (Date rec'd by registrar)

J. P. Franklin M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 19 47 at 11- P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 46 to Mar 31 19 47

and that I last saw her alive on Mar. 31 19 47

Immediate cause of death	DURATION
Amyotrophic Lateral Sclerosis	3½ yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Arthur F. Jones M. D. M. D. or other

Address 110 S. Centre St. Date signed 4-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

Dr. Walvertone

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

02311

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Allegany

County Allegany

City or town Luke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred:

117 Mullen Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Luke

(If outside city or town limits, write RURAL and give nearest town)

Street No. 117 Mullen St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Ellen Bryan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William P. Bryan

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 7, 1896

8. AGE: Years	Months	Days	If less than one day
50	9	29	hrs. min.

9. Birthplace Shaw, Mineral, West Virginia (Town, county, and state)

10. Usual occupation Home wife

11. Industry or business Own home

FATHER 12. Name Edward O'Brien

13. Birthplace Scotland

MOTHER 14. Maiden name Mary Ellen Byrnes

15. Birthplace Midland Md.

16. Informant William P. Bryan

Address Luke, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 10, 1947 (month) (day) (year)

Cemetery or crematory St Peters Cemetery

Location Westernport, Md.

18. Funeral director Ellsworth S. Beal

Address Westernport, Md.

19. March 10 1947 Hazen Baker M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1946 to March 6 1947

and that I last saw h alive on March 6 1947

	DURATION
Immediate cause of death	
Due to Uremia Coronary Thrombosis	2 yr.
Due to	
Other conditions Pyelonephritis	10 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James P. Clement M. D. M. D. or other

Address Piedmont Md. Date signed 3/9/47

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

02312

Reg. Dist. No. 40

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred: 538 N. Center St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 538 N. Center St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Vernia Bryson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife James Bryson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 1886

8. AGE:

Years	Months	Days	If less than one day
60	7	?	..... hrs. ..... min.

9. Birthplace Westernport Md. (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name John Mc Sweeney

13. Birthplace Ireland

MOTHER 14. Maiden name Bessie Mac Fadine

15. Birthplace Ireland

16. Informant James Bryson

Address 538 N. Center St. Cumberland. Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Mar 19, 1947 (month) (day) (year)

Cemetery or crematory St. Patrick's Cem.

Location Cumberland, Md

18. Funeral director Louis Stein, Inc.

Address Cumberland Md.

19. March 18, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1947, at 9-15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19..... and that I last saw h.. alive on 14 Mar. 1947

	DURATION
Immediate cause of death Mediastinal ? cancer	4 months?
Due to cause & type of above not determined.	
Due to	
Other conditions Diabetes mellitus, mild	2 years

(Include pregnancy within 3 months of death)

Major findings of operations none done

Date of op.

Autopsy results not obtained

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Alfred Va Dem M. D. or other

Address Cumberland, Md. Date signed 18 Mar 47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-1)

CERTIFICATE OF DEATH

02313

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
130 Grand Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 130 Grand Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: BRUCE CHESNUT

3.(b) Social Security Number: 705-09-7939

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 1, 1879

8. AGE: Years	Months	Days	If less than one day
67	3	12	..... hrs. ..... min.

9. Birthplace: Hustontown, Penna.
(Town, county, and state)
10. Usual occupation: Freight Conductor
11. Industry or business: B. & O. Railroad
FATHER 12. Name: George Chesnut
FATHER 13. Birthplace: Penna.
MOTHER 14. Maiden name: Elizabeth Lyon
MOTHER 15. Birthplace: Penna.
16. Informant: Mrs. Alice Hauger
Address: 130 Grand Ave. Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 15, 1947 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Cumberland, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.
19. March 15 1947 (Date rec'd by registrar) Joseph C. Trimble, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 13, 1947, at 1:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1946, to March 13 1947
and that I last saw h... alive on March 13 1947

Immediate cause of death	DURATION
Coronary Occlusion	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. L. Leason M.D.
M. D. or other
Address: 26 Wash. St. Cumberland Md. Date signed: 3/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

Within corporate limits

DR. GRACIE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

02314

Reg. Dist. No. 40

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 12 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County HARDY
City or town MOOREFIELD
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. BETTIE W. CHRISMAN

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife BRANSON CHRISMAN
6.(c) If alive, give age dead years

7. Birth date of deceased (mo., day, yr.) 4/24/1855

8. AGE: Years	Months	Days	If less than one day
91	10	8	hrs. min.

9. Birthplace WEST VIRGINIA (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name MORTIMER GAMBLE
13. Birthplace VIRGINIA

MOTHER
14. Maiden name ELIZABETH CUNNINGHAM
15. Birthplace VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 4-1947 (month) (day) (year)
Cemetery or crematory Oliver
Location Moorefield - W Va
18. Funeral director P. E. Thrush & Son
Address Moorefield - W Va

19. March 4 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 2 1947 at 10:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 18 1947, to 3/2 1947
and that I last saw h- alive on 3/2 1947

	DURATION
Immediate cause of death Influenza & age	
Due to Fractured Pelvis	
Due to Fall in home	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. G. Grace M. D. or other
Address Cumberland Md Date signed 3/4-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02315

Reg. Dist. No. 4

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany Cumberland

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mos. 22 days

Hospital, institution, or street address where death occurred: Emergency Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 207 Bedford St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Myrtle Mae Cline

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 25 1946

8. AGE: Years 0 Months 8 Days 22 If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation none

11. Industry or business —

FATHER 12. Name James Cline

13. Birthplace Ridgeley W. Va.

MOTHER 14. Maiden name Mary Davis

15. Birthplace Wellsburg W. Va.

16. Informant James Cline

Address 207 Bedford St, Cumberland, Md.

17. burial Date thereof 19 Mar 1947 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland Md.

19. March 19, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1947, at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw her alive Dead March 17 1947

Immediate cause of death Lobar pneumonia — DURATION about 10 days

Due to

Due to

Other conditions Emphysema

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address Cumberland Md. Date signed 3/18/47

2-35

Within corporate limits

DR. F. CAWLEY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

02316

Reg. Diat. No. 40

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 26 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County Mineral
City or town KEYSER
(If outside city or town limits, write RURAL and give nearest town)
Street No. RT. 2 BOX 122
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME E.
MR. ELMER COATES

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MINNIE [redacted] May Criss
6.(c) If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.) JULY 18, 1878

8. AGE: Years	Months	Days	If less than one day
68	8	6	hrs. min.

9. Birthplace [redacted] Bradford, Penna
(Town, county, and state)
10. Usual occupation FARMER
11. Industry or business farm

FATHER
12. Name BEN COATES
13. Birthplace [redacted] Pennsylvania

MOTHER
14. Maiden name LINDA HAMMOND
15. Birthplace PENNSYLVANIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 26, 1947 (month) (day) (year)
Cemetery or crematory Mineral Baptist Church Cem
Location Rt. #2, Keyser, W. Va.

18. Funeral director N. L. ROGERS,
Address KEYSER, W. VA.

19. March 25, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 24 19 47 at 3:35 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN 17 1947 to MARCH 24 1947
and that I last saw h[redacted] alive on MARCH 22 1947

Immediate cause of death	DURATION
LYMPHOSARCOMA.	
Primary site, undetermined.	
Due to Duration: Approximately six months. C.W.B.	
Due to Both axillary regions showed adenopathy. Skin metastases over anterior left chest wall.	
Other conditions Abdomen, negative.	

(Include pregnancy within 3 months of death)
Major findings of operations POSITIVE BIOPSY Date of op.
Autopsy results NOT DONE: no autopsy.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank Cawley M.D.
M. D. or other
Address Memorial Hospital Date signed 3/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Within corporate limits

02317

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 Years

Hospital, institution, or street address where death occurred:
207 Polk St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 207 Polk St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Henry W. Connor

3.(b) Social Security Number: 220-10-0568A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Rizer Connor

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): August 1 1870

8. AGE: Years	Months	Days	If less than one day
76	7	9	....hrs. ....min.

9. Birthplace: Midland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: Pressure Operator

11. Industry or business: Cumberland & Allegany Gas Co

FATHER 12. Name: Thomas Connor

FATHER 13. Birthplace: Scotland

MOTHER 14. Maiden name: Janet Carlew

MOTHER 15. Birthplace: Scotland

16. Informant: Miss Bertha Connor

Address: 207 Polk St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/12/47 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. March 12, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1947 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1946 to March 10 1947 and that I last saw h... alive on March 8 1947

Immediate cause of death	DURATION
Cerebral Hemorrage	
Due to Arteria Sclerosis	
Due to	
Other conditions Chronic prostatitis	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: D Keeler M. D. or other

Address: 122 Bedford St Date signed 3/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-35

Within corporate limits

M

A. Jones
329 Comb. St.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02318

Reg. Diat. No. 40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs

Hospital, institution, or street address where death occurred:
534 Broadway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 534 Broadway
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Maud Grace Corrick

3. (b) Social Security Number 220-03-7584

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife James L. Corrick

6.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Jan 31, 1905

8. AGE:

Years	Months	Days	If less than one day
42	1	29	..... hrs. ..... min.

9. Birthplace Harman Randolph Co. W. Va
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER
12. Name Albert Wimer
13. Birthplace Cigleville W. Va.

MOTHER
14. Maiden name Susan Harper
15. Birthplace Harman W. Va

16. Informant James L. Corrick
Address 534 Broadway

17. Burial Date thereof Mar 23 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. March 22, 1947 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20 19 47 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 46, to Mar 20 19 47
and that I last saw h.. alive on Mar 16 19 47

	DURATION
Immediate cause of death Pulmonary tuberculosis	5 years
Due to Diabetes mellitus	6 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M. D.
M. D. or other

Address 110 S. Centre St. Date signed 3-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

Within corporate limits

Dorcas

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02319

Reg. Diat. No. 40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred:

5 Lang Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Lang Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Stephen Conrothers

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of hueband or wife

6.(c) If alive, give age yeare

7. Birth date of deceased (mo., dey, yr.) ? 1873

8. AGE: Yeare 84 | Months | Days | If less than one day hrs. min.

9. Birthplace Taylor County W. Va.
(Town, county, and state)

10. Ueual occupation Cattle Dealer - Retired

11. Industry or businese Livestock

FATHER 12. Name Samuel Conrothers

FATHER 13. Birthplace W. Va.

MOTHER 14. Maiden name Harriet Poe

MOTHER 15. Birthplace W. Va.

16. Intormant Mrs James Walker

Address 513 E. Park Ave - Fairmont W. Va.

17. Burial (Burial, eremation, or removal. Which?) Date thereot March 25 1947 (month) (day) (year)

Cemetery or crematory Zion Memorial Park

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19 March 24 19 47 (Date ree'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 19 47 at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceaeed from Jan. 19 47, to 19

and that I last saw h alive on Jan. 19 47

Immediate cause of death	DURATION
Uraemia	2 mos
Due to Nephrosclerosis	2 yrs.
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. E. Summers M. D. or other

Address Cumberland Date signed 3/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please, write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1572)

02320

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: ~~516 Fort Ave~~ 507 Pine Ave

(If rurel, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Baby Girl Crabtree

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., dsy, yr.): March 17, 1947

8. AGE: Years | Months | Days | If less than one day: 1 hrs. min.

9. Birthplace: Cumberland, Md (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER — 12. Name: Leo Crabtree

13. Birthplace: Cumberland, Md

MOTHER — 14. Maiden name: Alberta Little

15. Birthplace: Cumberland, Md

16. Informant: Allegany Hospital

Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 18, 1947 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Cumberland, Md

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19 March 18, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 1947, at 2:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 1947, to March 17 1947

and that I last saw her alive on March 17 1947

Immediate cause of death	DURATION
Hydrocephalous	1 hour
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: B. M. Schindler M.D. M. D. or other

Address: 41 Greene St. Date signed: March 18, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Within corporate limits

DR. HODGES

02321

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 46

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 hours 30 minutes
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 3 HOURS 30 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PENNSYLVANIA County SOMERSET
City or town SALISBURY
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME BABY BOY DEAL

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife —
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 3-26-47

8. AGE: Years	Months	Days	If less than one day
—	—	—	3 hrs. 30 min.

9. Birthplace CUMBERLAND ALLEGANY MARYLAND (Town, county, and state)
10. Usual occupation NEWBORN
11. Industry or business

FATHER
12. Name DEAL, CLYDE
13. Birthplace PENNA

MOTHER
14. Maiden name LIVENGOOD, MARY ELIZ
15. Birthplace PENNA

16. Informant Clyde Deal
Address Salisbury Pa

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Mar 27-1947 (month) (day) (year)
Cemetery or crematory Meyersdale Union
Location Meyersdale Pa

18. Funeral director Stanley W. Thomas
Address Salisbury Pa

19. March 27 19 47 (Date rec'd by registrar) J. C. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26/ 19 47 at 5 45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3/26 19 47 to 3/26/ 19 47 and that I last saw h... alive on 3/26/47 19

Immediate cause of death	DURATION
Pulmonary atelectasis	3 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE W. F. Hodges M. D. or other
Address Cumberland Md Date signed 3/27/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

02322

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Woodland R.F.D. Rt 1, Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 years

Hospital, Institution, or street address where death occurred: /

How long in hospital or institution? /

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Woodland R.F.D. 1 Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. /
(If rural, give LOCATION)

2.(a) If veteran, name war: /

3.(a) FULL NAME: Virginia Stone Densmore

3.(b) Social Security Number: /

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female		Widowed

6.(b) Name of husband or wife: David H. Densmore

6.(c) If alive, give age: / years

7. Birth date of deceased (mo., day, yr.): July 6, 1858

8. AGE: Years: 89 | Months: 8 | Days: 16 | If less than one day: ...hrs. ...min.

9. Birthplace: Kingwood, W. Va.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER
12. Name: Edgar Stone
13. Birthplace: Unknown

MOTHER
14. Maiden name: Eliz. Hubbe
15. Birthplace: Unknown

16. Informant: Mrs. Walter Grandstaff

Address: ---

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 25 1947 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: M. E. Eichelberger

Address: Lonaconing, Md.

19. 3/25/47 (Date rec'd by registrar) 19 47 Jennie M. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1947 at 4 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1947, to March 22 1947 and that I last saw h... alive on March 20 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Henry W. Hodgson M.D.
M. D. or other

Address: Lonaconing Date signed March 23 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-35

Within corporate limits

DR. ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 516

CERTIFICATE OF DEATH

02323

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, Institution, or street address where death occurred: MEMORIAL Hospital

How long in hospital or institution? 20 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town BOWLING GREEN, CUMBERLAND, Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. Rt #6, Bowling Green (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME PHILIP Henry DEVINE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife BENNINGTON, ELLA 6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., dy., yr.) September 11, 1875

8. AGE: Years	Months	Days	If less than one day
71	6	18	hrs. min.

9. Birthplace W. VA., Calhoun Co. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Tin Mill Worker

FATHER 12. Name Patrick Devine

13. Birthplace Ireland

MOTHER 14. Maiden name Elmira Simmons

15. Birthplace France

16. Informant Glenn Devine

Address Rt #5, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1, 1947 (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Cumberland, Maryland

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. April 1, 1947 (Date rec'd by registrar) J. P. Franklin Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 29 1947, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 25 1947 to 1947

and that I last saw h[illegible] alive on Monday 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. E. Campbell M. D. or other

Address Cumberland Md. Date signed 3/31/47

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02324

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 133 Paca St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: DARLENE MARIE DICK

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Infant

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar. 23, 1947

8. AGE: Years	Months	Days	If less than one day
0	0	2	hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: John Dick
13. Birthplace: Westernport, Md.

MOTHER
14. Maiden name: Loma May Sowers
15. Birthplace: Thomas, W. Va.

16. Informant: Mr. John Dick
Address: 133 Paca St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 26, 1947 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. March 26, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 25, 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23, 1947, to March 25, 1947
and that I last saw h... alive on March 25, 1947

Immediate cause of death	DURATION
premature baby	3 days
Due to: placenta previa	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other
Address: 59 Greene St. Date signed 3-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Within corporate limits

DR. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

02328

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 18 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town FROSTBURG
(If outside city or town limits, write RURAL and give nearest town)

Street No. 120 FROST AVENUE
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME DIEHL, MARY E. MRS

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	MARRIED

6.(b) Name of husband or wife DIEHL, RUSSELL C.

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 9-18-90

8. AGE: Years	Months	Days	If less than one day
56	6	13	...hrs. ...min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name LAYMAN, GEORGE

13. Birthplace MARYLAND

MOTHER 14. Maiden name CROWE, LOU

15. Birthplace MARYLAND

16. Informant MRS. ROBERT WILSON,

Address CUMBERLAND, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Apr. 3, 1947 (month) (day) (year)

Cemetery or crematory GREENMOUNT CEMETERY

Location CUMBERLAND, MD.

18. Funeral director J. P. Dunn

Address Frostburg Md.

19. April 2, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3.31. 1947 at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3.13. 1947 to 3.31. 1947 and that I last saw h.. alive on 3.31. 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage From	
Due to Generalized Arteriosclerosis.	3.17.47
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Chronic pelvic inflammation Date of op. 3.14.47

Autopsy results See cause of death.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 4-1-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

McHenry 02325 Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners hospital

How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Avilton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Robert Patrick Dishong

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	------

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 29, 1947

8. AGE: Years | Months: 1 | Days: 21 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frostburg Allegany, Md.

(Town, county, and state)

10. Usual occupation: infant

11. Industry or business:

FATHER — 12. Name: Chas. W. Dishong

13. Birthplace: Avilton, Md.

MOTHER — 14. Maiden name: Betty L. McKenzie

15. Birthplace: Avilton, Md.

16. Informant: Chas. W. Dishong

Address: Avilton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 20 1947 (month) (day) (year)

Cemetery or crematory: St. Anns

Location: Avilton, Md.

18. Funeral director: J. R. Durst

Address: Frostburg Md.

19. 3-20 1947 (Date rec'd by registrar) Wm Harvey V. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 19 1947, at 2 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 28 1947, to Mar 19 1947

and that I last saw h... alive on Mar 19 1947

Immediate cause of death	DURATION
Prematurity	one day
Marasmus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm C Lane Jr MD M. D. or other

Address: Frostburg Md Date signed: 3-20-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

02326

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Miners hospital
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Avilton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William Patrick Dishong

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): January 29 1947

8. AGE: Years | Months: 1 | Days: 4 | If less than one day: ... hrs. ... min.

9. Birthplace: Frostburg Allegany, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Chas. W. Dishong
13. Birthplace: Avilton, Md.

MOTHER
14. Maiden name: Betty Mc Kenzie
15. Birthplace: Avilton Md.

16. Informant: Chas. W. Dishong
Address: Avilton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 5 1947 (month) (day) (year)
Cemetery or crematory: St. Anne's Cemetery
Location: Avilton Md.

18. Funeral director: J. B. Durst
Address: Frostburg Md.

19. 3-5 (Date rec'd by registrar) 1947 Mrs Hailey V. Pye Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 1947, at 2:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 28 1947, to Mar 2 1947
and that I last saw him alive on Mar 2 1947

Immediate cause of death	DURATION
Prematurity	1 mo 4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: W M Lane Jr M D
M. D. or other
Address: Frostburg Md. Date signed 3-5-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

Within corporate limits

DR GROVE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02329

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 hrs. 40 MINUTES

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 10 hrs 40 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town ~~CUMBERLAND~~ Westernport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 221 VINE ST EXT
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ELLSWORTH DOHM MR

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife CARRIE DOHM

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., dy., yr.) MAY 5, 1903

8. AGE:	Years	Months	Days	If less than one day
	43	10	10	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation W. VA PULP AND PAPER MILL

11. Industry or business

FATHER 12. Name THOMAS ~~DAUM~~ Dohm

13. Birthplace W. VA

MOTHER 14. Maiden name RACHEL DUCKWORTH

15. Birthplace MARYLAND

16. Informant Hospital Records

Address

17. Burial (Burial, cremation, or removal, which?) Date thereof March 18, 1947 (month) (day) (year)

Cemetery or crematory Shaw Cemetery

Location Westernport, Md

18. Funeral director Edmonds & Bond

Address Westernport Md.

19. March 17, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1947, at 12:00 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 15, 1947, to March 15, 1947

and that I last saw h alive on 18

Immediate cause of death	DURATION
Massive gastric hemorrhage	1 day
Due to Gastric ulcer	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. R. Irons M.D. M. D. or other

Address Medical Bldg Cumberland, Md Date signed 3-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02327

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? about 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: ~~R. F. D. 2~~ Flintstone Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. F. D. #2
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Delmer Simon Dolly

3.(b) Social Security Number: 220-10-7369

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Belle Imes

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): November 11, 1903

8. AGE: Years	Months	Days	If less than one day
43	3	21	...hrs. ...min.

9. Birthplace: Spruce Mountain, Pendleton, West Virginia
(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business: Allegany Co. Commissioners

FATHER
12. Name: Alfred James Dolly
13. Birthplace: Spruce Mountain, W. Va.

MOTHER
14. Maiden name: Elizabeth Mallow
15. Birthplace: Spruce Mountain, West Va.

16. Informant: Mrs. Carl E. Dolly
Address: 46 Bedford St, Cumberland, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 5, 1947 (month) (day) (year)

Cemetery or crematory: Dolly Cemetery

Location: Near Flintstone, Maryland.

18. Funeral director: John J. Hafer

Address: Cumberland, Maryland.

19. March 5, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 19 47 at 7.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive March 2 19 47

Immediate cause of death	DURATION
Pulmonary hemorrhage	about 3 hours
Due to Crushed chest, from auto accident.	
Due to	
Other conditions Depressed fracture, right temporal region.	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 3-2-1947

Where did injury occur? Route 40-6Mi. east of Cumberland Md. (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) as above

Means of injury: Blue Ridge Bus hit pick up truck he was in Injured at work? yes

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. (M. D. or Coroner)

Address: Cumberland Md. Date signed: 3-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

CERTIFICATE OF DEATH

02330

Reg. Dist. No. 90

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?:
Hospital, institution, or street address where death occurred: 23 Washington St.
How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 23 Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Geraldine Donahue

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Hugh Donahue
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 13, 1894

8. AGE: Years	Months	Days	If less than one day
52	9	6	hrs. min.

9. Birthplace: Mt. Savage Allegany, Md.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: home

FATHER
12. Name: Michael Hughes
13. Birthplace: Ireland

MOTHER
14. Maiden name: Annie Porter
15. Birthplace: Maryland

16. Informant: Mrs. Paul Conroy
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 22 1947 (month) (day) (year)
Cemetery or crematory: St. Michaels
Location: Frostburg Md.
18. Funeral director: J. R. Hirst
Address: Frostburg Md.

19. 3-21 1947 (Date rec'd by registrar) Mrs. Nancy V. Poe (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 20 1947 at 12.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 11 1947, to Mar 20 1947
and that I last saw her alive on Mar 19 1947

Immediate cause of death	DURATION
(a) Ca. Nephritis	several years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wm. McLane Jr. M.D. M. D. or other
Address: Frostburg Md. Date signed: 3-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

02331

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Miners Hospital

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 24 Water

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Daniel Hudson Dunst

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife: Harriet Dunst

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar 3 - 1861

8. AGE:

Years	Months	Days	If less than one day
85	11	29	..... hrs. ..... min.

9. Birthplace: Grantsville - Garrett - Md. (Town, county, and state)

10. Usual occupation: retired

11. Industry or business: Grocery - Clerk

FATHER 12. Name: Michael Dunst.

13. Birthplace: Md.

MOTHER 14. Maiden name: Julia Yeast

15. Birthplace: Md.

16. Informant: Grant Dunst

Address: Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 4-1947 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg

18. Funeral director: J. J. Dunst

Address: Frostburg, Md

19. 3-4 (Date rec'd by registrar) 1947 Mrs. Nancy V. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 1, 1947, at 6.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb-18, 1947, to Mar 1, 1947 and that I last saw him alive on Mar 1, 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 Day
Left Hemiplegia	
Due to:	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. M. McLane Jr. M.D. M. D. or other

Address: Frostburg Md Date signed: 3-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1 - 35

Within corporate limits: Yes.

M. E. B. Owens.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-2)

CERTIFICATE OF DEATH

* 02332

Reg. Diat. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 wks.
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 1 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: R.F.D. #3 Cumberland, Md Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. F. D. #4, Oldtown Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Richard Van Everett

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 9, 1947

8. AGE: Years: | Months: 1 | Days: 51 20 | If less than one day: hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Worthington L. Everett
13. Birthplace: West Va.

MOTHER
14. Maiden name: Bertrice Childress
15. Birthplace: West Va.

16. Informant: W.L. Everett
Address: R.F.D.#3 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/4/1947 (month) (day) (year)
Cemetery or crematory: Camp Hill Ceme.
Location: Paw Paw West Va.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. March 4 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1, 1947, at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 1947, to March 1 1947
and that I last saw h... alive on March 1 1947.

	DURATION
Immediate cause of death: Intestinal Obstruction.	31 days
Due to: Abnormal intestinal development.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M E B Owens M.D.
M. D. or other
Address: 133 V a ave Date signed: 3/5/47

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

02333

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 306 Cumberland St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Baby Boy FARRELL

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	S.

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 15, 1947

8. AGE: Years | Months | Days: 1 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: John V. Farrell
13. Birthplace: Mt. Savage, Md.

MOTHER
14. Maiden name: Mary E. Habig
15. Birthplace: Cumberland, Md.

16. Informant: John V. Farrell
Address: 306 Cumberland St. Cumb. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 17, 1947 (month) (day) (year)
Cemetery or crematory: St. Patricks Cem.
Location: Mt. Savage, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. March 17, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 Mar 1947 at 1 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Mar 1947 to 16 Mar 1947 and that I last saw h.. alive on 16 Mar 1947

Immediate cause of death	DURATION
Congenital Atelectasis	
Due to (a) Prematurity 7mo	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Dallas B. Whitworth M. D. or other
Address: 112 Bedford St. Date signed: 16 Mar 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

02334 2nd

Reg. Diat. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
miners Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 38 Centennial
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Wm Zingel

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: alice Zingel
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 2-1872

8. AGE:

Years	Months	Days	If less than one day
75	2	21	..... hrs. ..... min.

9. Birthplace: Zingel-Grantt md.
(Town, county, and state)
10. Usual occupation: retired
11. Industry or business: clay miner
FATHER 12. Name: Henry Zingel
13. Birthplace: Germany
MOTHER 14. Maiden name: Sarah McKenzie
15. Birthplace: Pa
16. Informant: Robert Zingel
Address: Frostburg, md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 25-1947 (month) (day) (year)
Cemetery or ~~cremetery~~: Zingel
Location: Zingel md.
18. Funeral director: J. J. Dunn
Address: Frostburg md
19. 3-24 1947 Mrs Nancy N Rae Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 23 1947, at 6 20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 16 1947 to Mar 23 1947 and that I last saw him alive on Mar 22 1947

Immediate cause of death	DURATION
Chr. Myocarditis	Several months
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W O'M Lane Jr M D M. D. or other
Address: Frostburg md Date signed Mar 24 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (746)

CERTIFICATE OF DEATH

* 02335

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: 951 Bedford St. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
951 Bedford St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 951 Bedford St.
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st World War

3.(a) FULL NAME: John Thomas Flynn

3.(b) Social Security Number: 236-05-4245

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Irene Lisaure
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 4 1894

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
52	10	10		

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Supt. of Construction
11. Industry or business: Vandegrift Construction Co.

FATHER
12. Name: Thomas Flynn
13. Birthplace: West Virginia.

MOTHER
14. Maiden name: Uhknown
15. Birthplace

16. Informant: Irene L. Flynn
Address: 951 Bedford St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 17 MAR 1947 (month) (day) (year)
Cemetery or crematory: Trinity Lutheran Cemetery
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. March 16, 19 47 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 19 47, at 12.45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw him alive on March 14 19 47

Immediate cause of death	DURATION
Angina Pectoris	about 15 minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.
23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or
Address Cumberland Md Date signed 3/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02336

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: W Va County: Mineral

City or town: Ridgeley (If outside city or town limits, write RURAL and give nearest town)

Street No. 76 River View Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Joseph Michael Fryer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Jan 6 1947

8. AGE: Years — Months 2 Days 9 If less than one day ... hrs. ... min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: none.

11. Industry or business

FATHER — 12. Name: Charles Fryer

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Elizabeth Malamphy

MOTHER — 15. Birthplace: W. Va.

16. Informant: Charles Fryer

Address: Ridgley W Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 18, 1947 (month) (day) (year)

Cemetery or crematory: St Peters & Pauls

Location: Fayette Street

18. Funeral director: Louis Stein Inc

Address: Cumberland Md.

19. March 17 1947 (Date rec'd by registrar) J. P. Franchini, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 1947, at 1.30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar. 14 1947, to Mar. 15 1947

and that I last saw him alive on Mar 15 1947

Immediate cause of death	DURATION
Lobar Pneumonia	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Arthur J. Jones M. D. (M. D. or other)

Address: 110 S. Centre St. Date signed: 3-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Arthur Lewis

Within corporate limits

M E B Owens

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 922 CD

02337

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 weeks

Hospital, institution, or street address where death occurred: 700 Lafayette Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Hampshire

City or town Little Cacapon

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Margaret Esther Ginevan

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife George W. Ginevan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1862

8. AGE: Years	Months	Days	If less than one day
84	6	8	..... hrs. ..... min.

9. Birthplace Bloomery, Hampshire Co. W. Va.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business at Home

FATHER 12. Name George Belford

13. Birthplace W. Va.

MOTHER 14. Maiden name Esther Hyatt

15. Birthplace W. Va.

16. Informant Mrs Mae Klein

Address 700 Lafayette Ave - Cumb. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3, 1947 (month) (day) (year)

Cemetery or crematory Ginevan Cemetery

Location Little Cacapon W. Va.

18. Funeral director John J. Hafer

Address Cumberland Md.

19. April 1, 1947 (Date rec'd by registrar) J. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 19 47 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 19 47 to March 30 19 47 and that I last saw h[illegible] alive, on March 30 19 47

Immediate cause of death Valvular Heart Disease

Due to Cirhosis Schosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M E B Owens M.D.
M. D. or other

Address 132 Virginia Ave Date signed 3/31/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (35)

CERTIFICATE OF DEATH

02338

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address, where death occurred: Memorial Hospital

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 38 Centennial

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Glass

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	infant

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 3 - 1946

8. AGE: Years 1 | Months 2 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace: Frostburg - Alleg - Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Francis Glass

13. Birthplace: Md.

MOTHER 14. Maiden name: Annie Zimpel

15. Birthplace: Frostburg Md

16. Informant: Mrs Glass

Address: Frostburg

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 11-1947 (month) (day) (year)

Cemetery or crematory: Zimpel

Location: Zimpel, Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md

19. 3-11 (Date rec'd by registrar) 1947 Mrs. Nancy L. Rice Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9 1947, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 27 1947, to Mar 9 1947

and that I last saw her alive on Mar 9 1947

Immediate cause of death	DURATION
(a) Acute Nephritis	4 Days
Due to: (b) Measles	10 Days
Due to: (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: W D McCane Jr M.D. M. D. or other

Address: Frostburg Md Date signed: 3-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

DR. HAWKINS
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

02339

CERTIFICATE OF DEATH

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND (If outside city of town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State MARYLAND County GARRETT
City or town ~~MCHENRY~~ McHenry (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME MRS. AMELIA GLOTFELTY
3. (b) Social Security Number None

4. Sex FEMALE
5. Color or race WHITE
6.(a) Single, married, widowed, or divorced MARRIED
6.(b) Name of husband or wife JOHN GLOTFELTY
6.(c) If alive, give age 76 years
7. Birth date of deceased (mo., day, yr.) December 27, 1874
8. AGE: Years 72 Months 2 Days 11 If less than one day ... hrs. ... min.
9. Birthplace MARYLAND, Garrett County (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name ~~SUTER~~ Franklin Suter
13. Birthplace ~~MARYLAND~~, Bedford County, Penna

MOTHER
14. Maiden name Lucinda Speicht
15. Birthplace Garrett County, Md.

16. Informant LESTER GLOTFELTY
Address MCHENRY, MARYLAND

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof March 11, 1947 (month) (day) (year)
Cemetery or crematory Flatwood Cem
Location Near Accident, Md.
18. Funeral director Emroy Bolden
Address Oakland md
19. March 11, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 8, 1947 at 9:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 26 1947 to Mch 8 1947 and that I last saw her alive on Mch 8 1947

Immediate cause of death Diff Supp. Peritonitis Adynamic Ileus — DURATION: Mar 8
Due to Ileus
Due to Ruptured appendix Close to Caecum
Other conditions Peritonitis Pelvic abscess (Include pregnancy within 3 months of death)
Major findings of operations Abdominal
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A H Hawkins M. D. or other
Address Cumberland Date signed 3-9-47

2 - 35

Within corporate limits

Dr. F. Wms.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-6)

CERTIFICATE OF DEATH

02340

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 41 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town LONACONING (If outside city or town limits, write RURAL and give nearest town)
Street No. Watercliffe Street (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Eleanor Goldsworthy

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Vance Goldsworthy 6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) September 5, 1894

8. AGE: Years 52 Months 6 Days 2 If less than one day ... hrs. ... min.

9. Birthplace MARYLAND, Frostburg, Alleg. County (Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name Henry Spitznas

FATHER 13. Birthplace MARYLAND, Frostburg.

MOTHER 14. Maiden name MARTHA LEMMERT

MOTHER 15. Birthplace MARYLAND, Mt. Savage

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 10, 1947 (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg, Md.

18. Funeral director Ellsworth S. Beall.

Address Western Port Md.

19. March 10, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 7 1947 at 1:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5. 17. 1946 to 3-7- 1947 and that I last saw h... or ...alive on 3-7- 1947

	DURATION
Immediate cause of death Auricular Flutter	
Due to Auricular Fibrillation	
Due to	
Other conditions Polyarthritis. Epilepsy. (Include pregnancy within 3 months of death)	

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm F. Williams M. D. or other

Address Cumberland Date signed 3-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-35

Within corporate limits

Van Owner.

02341

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Diat. No. 40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs.

Hospital, institution, or street address where death occurred:

605 Washington St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 605 Washington St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Miss Elizabeth Griffith

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 23, 1874

8. AGE: Years 72 | Months 6 | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace Austin W. Va.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business At Home

FATHER 12. Name Wm Griffith

13. Birthplace Wales

MOTHER 14. Maiden name Annie Bohmer

15. Birthplace England

16. Informant Frank Myers

Address 605 Wash. St Cumb. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 24, 1947 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland Md.

18. Funeral director John J. Hafer

Address Cumberland Md.

19. Mar 24 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Only on 21 mo. 1947 to ..... 19.....

and that I last saw h... alive on 21 mo. 47 ..... 19.....

Immediate cause of death Acute Coronary Thrombosis — DURATION 1½ hours.

Due to Arterial Hypertension — years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Alfred Vance M. D. or other

Address 110 S. Centre St Date signed 22 mo. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH (13)

02342

Reg. Diat. No. 40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 2 Hours 35 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State West Virginia County Garrett

City or town Gormania
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Roger Lee Harvey

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 16, 1946

8. AGE: Years	Months	Days	If less than one day
1	—	25	hrs. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Warren Harvey

13. Birthplace Maryland

MOTHER 14. Maiden name Ruby Shreve

15. Birthplace Maryland.

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 4, 1947 (month) (day) (year)

Cemetery or crematory Oak Grove Cemetery

Location Near Harmans, Garrett Co., Md.

18. Funeral director Herbert C. Leichliter

Address Oakland, Md.

19. Mar 7, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1947, at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Mar 1:00 P.M. 1 Mar. 1947, to 3:35 P.M. 1 Mar 1947.

and that I last saw him alive on 1 Mar 1947.

Immediate cause of death	DURATION
Bronchial Lobar Pneumonia	
Due to	
Due to	
Other conditions Septicemia Cerebral Edema.	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op. Septicemia

Autopsy results Confluent Lobar Pneumonia,

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Slow Jr M.D. M. D. or other

Address Memorial Hosp. Date signed 1 Mar. 47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

Within corporate limits

Dr. Briney or

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02343

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 yrs

Hospital, institution, or street address where death occurred:

17 Fifth St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 17 Fifth St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs Aretta Dove Hershberger

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: Hubert Hershberger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 15, 1913

8. AGE:

Years	Months	Days	If less than one day
33	2	23	..... hrs. ..... min.

9. Birthplace: Keyser Mineral Co. W. Va.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at Home

FATHER
12. Name: James A. Pearson
13. Birthplace: Midland Md.

MOTHER
14. Maiden name: Marie Whetzel
15. Birthplace: Keyser W. Va.

16. Informant: Marie Whetzel

Address: 17 Fifth St. Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 11, 1947 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland Md.

18. Funeral director: John J. Haley

Address: Cumberland Md.

19. March 11, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1947 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-7- 1947, to 3-8 1947

and that I last saw h... alive on 3-7 1947

Immediate cause of death	DURATION
pulmonary tuberculosis	10 Yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. Mann M.D. M. D. or other

Address: 59 Greene St. Date signed .....

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2 - 35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (100)

CERTIFICATE OF DEATH

02344

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 2.1/4 hrs
Hospital, Institution, or street address where death occurred:
Memorial Hospital Cumberland Md.
How long in hospital or institution? about 2.1/4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Clement St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Richard Hite

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 20, 1943

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
3	11	18		

9. Birthplace: Cumberland Allegany, Md (Town, county, and state)
10. Usual occupation: Child
11. Industry or business:

FATHER
12. Name: James Melvin Hite
13. Birthplace: Cumberland Md.

MOTHER
14. Maiden name: Phyllis Davis
15. Birthplace: Piedmont W.Va.

16. Informant: Norman L. Davis
Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 10, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Hermon Cemetery
Location: Cumberland, Md

18. Funeral director: John J. Hoffer
Address: Cumberland Md.

19. March 10, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1947 at 12.45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive Dead March 8 1947

Immediate cause of death	DURATION
Intercranial hemorrhage	about 3.1/2 hours
Due to a fracture of the skull	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 3-7-1947
Where did injury occur? Paw Paw (City or town) Morgan (County) W.Va. (State)
Injured at home, farm, industry, public place (where?): Highway & R. Ry B&O
Means of injury: Collision between train & Auto.

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. (M. D. or other)
Address: Cumberland Md Date signed: 3-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9.45-15M

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02345

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, Institution, or street address where death occurred: 303 Columbia Street
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 303 Columbia St
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Thomas James Hoban

3.(b) Social Security Number: 214-07-6098

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Margaret P. Sullivan Hoban
6.(c) If alive, give age: 66 years
7. Birth date of deceased (mo., day, yr.): Oct 9 - 1878

8. AGE:

Years	Months	Days	If less than one day
68	5	16	..... hrs. ..... min.

9. Birthplace: Lonaconing Md (Town, county, and state)
10. Usual occupation: Celanese Worker Retired
11. Industry or business: Celanese Corporation
FATHER 12. Name: John Hoban
FATHER 13. Birthplace: Ireland
MOTHER 14. Maiden name: Alice Sheridy
MOTHER 15. Birthplace: Virginia
16. Informant: Joseph Hoban
Address: Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 28 1947 (month) (day) (year)
Cemetery or crematory: St. Patrick's Cemetery
Location: Cumberland Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.
19. Mar 26, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 1947, at 6 A.M. about
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h. / M. alive Mar March 25 1947

Immediate cause of death	DURATION
Coronary occlusion	at once
Due to: Arteriosclerosis	several years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

Deputy Medical Examiner Allegany Co.

23. SIGNATURE: H. V. Deming M.D. M. D. or other
Address: Cumberland, Md. Date signed: 3-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(157) ★ 02346

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos.

Hospital, institution or street address where death occurred: Allegany Hospital

How long in hospital or institution? 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Oldtown (If outside city or town limits, write RURAL and give nearest town)

Street No.: — (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Michael William Hodel

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 9 1945

8. AGE:

Years	Months	Days	If less than one day
1	10	20	..... hrs. ..... min.

9. Birthplace: Cumberland Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER — 12. Name: John W. Hodel

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Juanita Kriner

MOTHER — 15. Birthplace: Maryland

16. Informant: John W. Hodel

Address: Oldtown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 1, 1947 (month) (day) (year)

Cemetery or crematory: St. Peter & Pauls Cem.

Location: Cumberland, Md.

18. Funeral director: Louis Klein, Inc.

Address: Cumberland Md.

19. March 31, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1946, to Mch 29 1947

and that I last saw h[illegible] alive on 3-29 1947

Immediate cause of death	DURATION
congestive heart failure	1 Yr
Due to: congenital malformation	
Due to: transplantation of great vessels	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: transplantation great vessels

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L. Klein M.D. M. D. or other

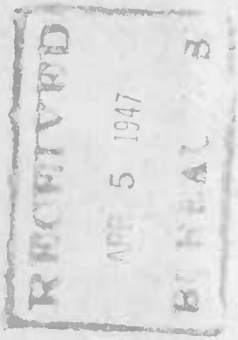
Address: 59 Greene St. Date signed: 3-29-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Briggs



1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02347 Form

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

74 Frost Ave.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 74 Frost Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Calvin Addison Holben

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Josephine Holben

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): May 31 - 1872

8. AGE:

Years	Months	Days	If less than one day
74	9	14	..... hrs. ..... min.

9. Birthplace: Ringgold, Jefferson - Pa.

(Town, county, and state)

10. Usual occupation: Insurance

11. Industry or business

FATHER

12. Name: A. E. Holben

13. Birthplace: Ringgold, Pa.

MOTHER

14. Maiden name: unknown

15. Birthplace

16. Informant: Mrs. Calvin Holben

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16-1947 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg

18. Funeral director: J. L. Dudrow

Address: Frostburg, Md

19. 3-15 1947 (Date rec'd by registrar) Mrs. Hawley H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 14 1947, at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19.. to Mar 14 1947

and that I last saw him alive on Mar 1 1947

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to: Hypertension	several years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. McLane Jr. M.D. M. D. or other

Address: Frostburg Md. Date signed: 3-14-47

1-35

mother's maiden name —

Lydia Geist

Birthplace —

Ruigold, Pa.

Within corporate limits

DR. MIRKIN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02348

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL

How long in hospital or institution? 30 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: 8 ALTAMONT TERRACE
(If outside city or town limits, write RURAL and give nearest town)

Street No. CUMBERLAND, MD.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARGIE HOLLEN

3.(b) Social Security Number: 215-14-6360

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3-7-21

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
26	0	3		

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation: SECRETARY

11. Industry or business: L.L.MARTIN, FORD'S DRUG STORE

FATHER
12. Name: FRED HOLLEN
13. Birthplace: W. Va.

MOTHER
14. Maiden name: MABEL RICE
15. Birthplace: MARYLAND

16. Informant: Mrs. Mabel Hollen
Address: 6 Altamont Terrace, Cumberland, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: Mar. 14, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. March 13 1947 (Date rec'd by registrar) Joseph A. Conklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAR. 10 1947 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 8 1947, to Mar 10 1947 and that I last saw h.. alive on Mar 10 1947

Immediate cause of death	DURATION
Cerebral edema	few hrs.
Due to: Lateral sinus Thrombosis, Suppurative	few wks.
Due to: Chronic mastoiditis, left, & otitis media,	Ser. yrs.
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operation: Chronic mastoiditis & normal lat. sinus Date of op. Feb. 13, 47

Autopsy results: (Above)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A. J. Mirkin MD M. D. or other

Address: 115 S. Centre St. Date signed: 3-11-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7)

CERTIFICATE OF DEATH

Diehl.

02349

Reg. Dist. No. 9 0

1. PLACE OF DEATH:

County Allegany

City or town Eckhart

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Eckhart

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Eckhart

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Marlyn Carol Humbertown

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 17, 1945

8. AGE: Years 2 | Months 1 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Eckhart Allegany, Md.

(Town, county and state)

10. Usual occupation None

11. Industry or business "

FATHER 12. Name Irvin J. Humbertown

13. Birthplace Eckhart, Md.

MOTHER 14. Maiden name Loretta Riger

15. Birthplace Frostburg, Md.

16. Informant Irvin J. Humbertown,

Address Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 22 1947 (month) (day) (year)

Cemetery or crematory Eckhart

Location Eckhart, Md.

18. Funeral director J. R. Durst

Address Frostburg Md.

19. 3-21 1947 Mrs. Nancy V. Re Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 28 1947 to 3.20 1947

and that I last saw h.. alive on 3.20 1947

Immediate cause of death	DURATION
Acute Bronchitis	3 days.
Due to	
Due to Whooping Cough	3 wks.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Diehl, M.D. M. D. or other

Address Frostburg Md. Date signed 3.21.47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

02350

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: McCoole
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: McCoole
(If outside city or town limits, write RURAL and give nearest town)
Street No. 110 Queen St.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Ernest A. Jackson

3.(b) Social Security Number: 236-01-8073-A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nullie Heironimus Jackson
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): May 15, 1880

8. AGE: Years	Months	Days	If less than one day
66	9	18	...hrs. ...min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business

FATHER
12. Name: Luther Jackson
13. Birthplace: Virginia

MOTHER
14. Maiden name: Viola Fogle
15. Birthplace: Virginia

16. Informant: Mrs. J.W. Goldsworthey
Address: Keyser, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/6/1947 (month) (day) (year)
Cemetery or crematory: Queens Point
Location: Keyser, W.Va.

18. Funeral director: B.W. Markwood
Address: Keyser, W.Va.

19. March 6 19 47 (Date rec'd by registrar) J. Grayson Baker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 3 19 47 at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 46 to March 3, 19 47
and that I last saw him alive on March 3 19 47

Immediate cause of death	DURATION
Myocarditis	
Due to	
Due to	
Other conditions: Arteriosclerosis, Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thad T. Huffman M.D. M. D. or other
Address: Keyser W Va. Date signed: 3-5-47

1-35

Within corporate limits

Dr. Mathews

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

02351

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: MOUNT SAVAGE.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Church Hill
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN E. JENKINS

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWER

6.(b) Name of husband or wife: FLORENCE YEAGER JENKINS
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8-7-65

8. AGE: Years	Months	Days	If less than one day
81	7	20	hrs. min.

9. Birthplace: ~~MARYLAND~~ Virginia (Town, county, and state)
10. Usual occupation: RETIRED
11. Industry or business: Carpenter
FATHER 12. Name: EDWARD JENKINS
FATHER 13. Birthplace: ~~PENNA~~ Virginia
MOTHER 14. Maiden name: ELLEN MASON
MOTHER 15. Birthplace: VA.
16. Informant: Robert L. Jenkins
Address: Mt. Savage, Md
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: March 30 1947 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Mt. Savage, Md.
18. Funeral director: John G. Hafer
Address: Cumberland, md.
19. March 29, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-27- 19 47 at 8:23 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-27- 19 47 to 3-27- 19 47 and that I last saw h. alive on 3-27- 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Generalized Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: None Date of op. None
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed: 3-29-47

1-35

Within corporate limits

02352

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 932

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
322 Bond St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 322 Bond St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Lillie May Johnson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wilbur H. Johnson
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 21, 1878

8. AGE: Years	Months	Days	If less than one day
68	9	10	____ hrs. ____ min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Hillary Brant
13. Birthplace: Maryland
MOTHER 14. Maiden name: Barbara Brotemarkle
15. Birthplace: Maryland
16. Informant: Mrs. Wilson Gross
Address: 159 Bedford St. Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 3 1947 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.
19. April 2 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 1947 at 4 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____ to ____ 19____
and that I last saw her alive March 31 1947
Immediate cause of death: Chronic myocarditis — DURATION: several years
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. M. D. or Coroner
Address: Cumberland Md. Date signed: 3-31-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

CERTIFICATE OF DEATH

02353

Reg. Diat. No. 40

1. PLACE OF DEATH:

County Allegany

City or town 30 Bedford St. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, Institution, or street address where death occurred:
30 Bedford St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 30 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Harry Kalbaugh

3.(b) Social Security Number 705-10-8193

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Elsie Kline

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 13, 1873

8. AGE: Years	Months	Days	If less than one day
73	9	5	..... hrs. ..... min.

9. Birthplace Westernport, Allegany, Md.
(Town, county, and state)

10. Usual occupation Retired Crossing Watchman

11. Industry or business Western Maryland RR

FATHER 12. Name John D. Kalbaugh

13. Birthplace Maryland

MOTHER 14. Maiden name Susan Simmons

15. Birthplace West Va.

16. Informant John Kalbaugh

Address 30 Bedford St Cumberland Md

17. buried (Burial, cremation, or removal. Which?) Date thereof Mar 21, 1947 (month) (day) (year)

Cemetery or crematory Philos Cemetery

Location Westernport, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19. March 20, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1947 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dead March 18 1947

Immediate cause of death Broncho-Pneumonia — DURATION: about one week

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or other

Address Cumberland, Md. Date signed 3-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Ma)

CERTIFICATE OF DEATH

02354

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 208 Decatur St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Baby Girl Kane

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 21, 1947

8. AGE:

Years	Months	Days	If less than one day
			hrs. 15 min.

9. Birthplace: Cumberland, Allegany Co., Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: William P. Kane

13. Birthplace: Cumberland, Md.

MOTHER 14. Maiden name: Betty Thomas

15. Birthplace: Wheeling, W. Va.

16. Informant: William P. Kane

Address: 208 Decatur St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/24/47 (month) (day) (year)

Cemetery or crematory: St Patricks Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. March 24, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 19 47, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Mar 1947, to 21 Mar 1947 and that I last saw h.. alive on 21 Mar 47 19

Immediate cause of death	DURATION
Congenital Atelectasis	
Due to Hydrops - Generalized	
Due to Cr	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Julius B Kuckworth M D M. D. or other

Address: 112 Bedford St Date signed 3-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Evidence for the change of age is shown on G 109 4/1/47

Within corporate limits

02355

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 67 yrs

Hospital, institution, or street address where death occurred:

27 Race St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 27 Race Street

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Frank M. Kastner

3.(b) Social Security Number 705-09-9872

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Catherine D. Corbin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 2, 1879

8. AGE:	Years	Months	Days	If less than one day
67	67	5	17	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation Retired Machinist

11. Industry or business B & O R R

FATHER 12. Name Anton Kastner

13. Birthplace Germany

MOTHER 14. Maiden name Mary Walberzyn Cross

15. Birthplace Germany

16. Informant Francis Kastner

Address 27 Race St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 22, 1947 (month) (day) (year)

Cemetery or crematory St Peters + Pauls Cem

Location Cumberland, Md.

18. Funeral director LOUIS STEIN, INC.,

Address Cumberland, Md

19. March 20, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1947, at 9 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/15/45 to 3/19/47 and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to	
Due to	
Other conditions — Prostatectomy. Asthma.	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John M. Rogers M.D.

M. D. or other

Address Cumberland Md Date signed 3/20/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 023564 0

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
24 N. Lee St.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24 N. Lee St.
(If rural, give LOCATION)
2.(a) If veteran, name war: 286-05-5788

3. (a) FULL NAME: Alfred J. Kasubick

3. (b) Social Security Number: 286-05-5788

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mildred Beauchamp
6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): Nov. 24, 1911

8. AGE: Years	Months	Days	If less than one day
35	3	8	..... hrs. ..... min.

9. Birthplace: Brisbin, Penna.
(Town, county, and state)
10. Usual occupation: Electrician
11. Industry or business: Electrical Repair shop
FATHER 12. Name: Albert Kasubick
13. Birthplace: Penna.
MOTHER 14. Maiden name: Margaret Kauczka
15. Birthplace: Penna.
16. Informant: Mrs. Mildred Kasubick
Address: 24 N. Lee St., Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 6, 1947 (month) (day) (year)
Cemetery or crematory: S. S. Peter & Paul Cem.
Location: Cumberland, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.
19. March 5, 1947 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 19 47 at about 8 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on Dead March 4 19 47
Immediate cause of death: Cardio-pulmonary hemorrhage — DURATION: At once
Due to: Shot himself with a 20 gauge shotgun
Due to: domestic troubles
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 3-4-47
Where did injury occur? Home Cumberland (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: as above Injured at work? no

23. SIGNATURE: H. V. Deming M.D. Deputy Medical Examiner - Allegany Co. H. V. Deming M.D. M. D. or other
Address: Cumberland Md Date signed: 3-4-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

02357 40
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 2 days 5 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 312 Avirett Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Walter J. Keifer

3.(b) Social Security Number 214-05-4966

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Helen Aman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 21 -1892

8. AGE: Years	Months	Days	If less than one day
54	7	8	..... hrs. ..... min.

9. Birthplace Cumberland, Maryland (Town, county, and state)
10. Usual occupation Engineer
11. Industry or business Queen City Brewing Co.

FATHER
12. Name Wantling Keifer
13. Birthplace Maryland

MOTHER
14. Maiden name Rose Hammersmith
15. Birthplace Maryland

16. Informant Helen Keifer
Address 312 Avirett Ave., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1, 1947 (month) (day) (year)
Cemetery or crematory St. Peter's & Paul's Cemetery
Location Cumberland, Maryland.

18. Funeral director Louis Stein, Inc.
Address Cumberland, Md.

19. March 31, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 19 47, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on Dead March 29 19 47

Immediate cause of death: Intercranial hemorrhage — DURATION: 2 days 5 1/2 hours
Due to: a fracture of the skull
Due to: a fall from a ladder while at work, Queen City Brewing Co.
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 3.27.47
Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?) Queen City Brewing Co
Means of injury Fell from ladder Injured at work? Yes
Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or other
Address Cumberland Md. Date signed 3/30/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02358

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DEACEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Emma A. Quinn Kenny

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Kenny
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec. 12, 1879

8. AGE: Years 67 | Months 2 | Days 29 | If less than one day: hrs. min.

9. Birthplace: Lonaconing Allegany Co. Md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER
12. Name: James Quinn
13. Birthplace: Ireland

MOTHER
14. Maiden name: Sara —
15. Birthplace: Ireland

16. Informant: Father Kenny
Address: Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 14 1947 (mouth) (day) (year)
Cemetery or crematory: St. Michaels Cemetery
Location: Frostburg, Md

18. Funeral director: M. E. Eichhorn
Address: Lonaconing, Md

19. Mar 13 1947 (Date rec'd by registrar) Jannette M Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 11 1947, at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mch 9 1947, to March 11 1947, and that I last saw h[illegible] alive on March 11 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry Dr. Hodgson M.D. M. D. or other
Address: Date signed:

Within corporate limits DR. HODGES & DR. COOPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159 013

02359

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH

County ALLEGANY

City or town CUMBERLAND, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address (if not in hospital): MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ~~MARYLAND~~ Pennsylvania County ALLEGANY

City or town NEAR FLINTSTONE Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war V

3.(a) FULL NAME BABY BOY KIFER (PREMATURE)

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH 28, 1947

8. AGE: Years | Months | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace MEMORIAL HOSPITAL Cumberland (Town, county, and state) Allegany Co., Md.

10. Usual occupation

11. Industry or business

FATHER 12. Name THURMAN KIFER

13. Birthplace PENNA.

MOTHER 14. Maiden name RUTH BORROR

15. Birthplace PENNA.

16. Informant Mr. Thurman Kifer

Address R.D.1. Flintstone, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 31, 1947 (month) (day) (year)

Cemetery or crematory Prosperity Cem.

Location Near Flintstone, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. March 30 1947 (Date rec'd by registrar) J. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 30, 1947 at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 Mar 1947 to 30 Mar 1947 and that I last saw h.i.m. alive on 29 Mar 47.

Immediate cause of death	DURATION
Cerebral Edema	
Due to Premature birth 6 months	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. L. Cooper M.D. M. D. or other

Address Memorial Hosp. Cumberland Date signed 30 Mar 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

Within corporate limits

DR. TOLSON

02360

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 21 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: PENNSYLVANIA County: BEDFORD
City or town: BEDFORD
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: X

3.(a) FULL NAME: MR. GEORGE KOONTZ

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife: ANNA DIEHL
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): OCTOBER 14, 1866

8. AGE: Years	Months	Days	If less than one day
80	5	12	hrs. min.

9. Birthplace: PENNSYLVANIA (Town, county, and state)
10. Usual occupation: RETIRED
11. Industry or business

FATHER
12. Name: WILLIAM KOONTZ
13. Birthplace: PENNSYLVANIA

MOTHER
14. Maiden name: SUSANNA MILLER
15. Birthplace: PENNSYLVANIA

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 29, 1947 (month) (day) (year)
Cemetery or crematory: Bedford Cemetery
Location: Bedford, Pa.
18. Funeral director: John J. Hoffman
Address: Cumberland, Md.

19. March 28, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 26, 1947, at 1:22 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-5- 1947, to 3-26- 1947 and that I last saw him alive on 3-25- 1947

Immediate cause of death	DURATION
Carcinoma Pancreas	
Due to	
Due to	
Other conditions: Benign hypertrophy prostate	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Howard L. Tolson, M.D. M. D. or other
Address: Cumberland, Md. Date signed 3-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93a ★

02361 40

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred: 924 Maryland Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 924 Maryland Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas Wimbert Lashley

3.(b) Social Security Number 220-10-8975

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Mary Blanche Imes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 27, 1876

8. AGE: Years	Months	Days	If less than one day
71	0	2	..... hrs. ..... min.

9. Birthplace: Artemas, Bedford Co., Pa. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General Work

FATHER 12. Name: Unknown

13. Birthplace

MOTHER 14. Maiden name: ?

15. Birthplace

16. Informant: Mrs. Humphrey Imes

Address: 924 Maryland Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Hope Christian Cemetery

Location: Near Artemas, Pa.

18. Funeral director: John J. Hoffer

Address: Cumberland, Md.

19. April 1, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29, 1947, at 1:15 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28, 1947, to March 29, 1947 and that I last saw h.i.m. alive on March 28, 1947

Immediate cause of death	DURATION
Cardio Vascular	
Due to	
Due to	
Other conditions: Arterio Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. Kesler M. D. or other

Address: Cumberland, Md. Date signed: 3/29/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

CERTIFICATE OF DEATH

02362

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany near

City or town Rural) Amcelle Acres, Cresaptown Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs -

Hospital, institution, or street address where death occurred:
Amcelle Acres -

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Rural) Near Cresaptown Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Amcelle Acres
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Edward L. Lease

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Arzella My Lease

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) — — 1860

8. AGE: Years	Months	Days	If less than one day
87			..... hrs. ..... min.

9. Birthplace Cresaptown, Allegany Maryland
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business Own

FATHER 12. Name Frederick L. Lease

13. Birthplace Maryland

MOTHER 14. Maiden name Hamit ——

15. Birthplace Unknown

16. Informant Samuel Lease

Address Amcelle Acres, Cresaptown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 29 1947 (month) (day) (year)

Cemetery or crematory Lease Cemetery

Location Cresaptown, Md.

18. Funeral director Lewis Stein, Inc.

Address Cumberland, Md.

19. 3/29/47 (Date rec'd by registrar) 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 19 47 at about 9 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on Dead March 26 19 47

Immediate cause of death

	DURATION
Coronary occlusion	at once
Due to Arterio sclerosis	several years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M. D. H. V. Deming M.D.
M. D. or Coroner

Address Cumberland Md. Date signed 3-27-47

1-35

Within corporate limits

Dr. Schindler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

02363

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 68 years

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 221 Mary St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Rebecca Ella Leasure

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Divorced

6.(b) Name of husband or wife: Ward Leasure

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): January 19, 1879

8. AGE:

Years	Months	Days	If less than one day
68	1	19	...hrs. ...min.

9. Birthplace: Cumberland, Maryland
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Own home

FATHER

12. Name: Charles Kerns

13. Birthplace: ?

MOTHER

14. Maiden name: Millie Rabinette

15. Birthplace: Allegany Co., Maryland

16. Informant: Alice Trout

Address: 221 Mary St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 10 47 (month) (day) (year)

Cemetery or crematory: Cumberland, Md.

Location: Zion Memorial Park

18. Funeral director: John J. Hoffman

Address: Cumberland, Md.

19. March 10, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8, 1947, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 25 1947 to March 8 1947 and that I last saw her alive on March 8 1947.

Immediate cause of death	DURATION
Bronchopneumonia	Days
Due to Generalized arteriosclerosis	years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. M. Schindler M.D.
M. D. or other

Address: 41 Greene St. Date signed: March 10/47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3d)

CERTIFICATE OF DEATH

02364

Dr Paul M. Wilson

Piedmont, W. Va.

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Barton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Barton

(If outside city or town limits, write RURAL and give nearest town)

Street No.: High Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Longridge

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Mathew Longridge

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 10, 1862

8. AGE:

Years	Months	Days	If less than one day
84	4	23	hrs. min.

9. Birthplace: Scotland

(Town, county, and state)

10. Usual occupation: House work

11. Industry or business: own home

FATHER

12. Name: James Kirk

13. Birthplace: Scotland

MOTHER

14. Maiden name: Jane Lamot

15. Birthplace: Scotland

16. Informant: Wellington Longridge

Address: Barton, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof: March 6, 1947 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cemetery

Location: Moscow, Maryland

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. March 6 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 19 47 at 12:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26 19 46 to Mar. 3 1947 and that I last saw h.e.r alive on March 1 19 47

Immediate cause of death	DURATION
Chronic Myocarditis	
and Myocardial Degeneration, not	
Specified as Rheumatic,	One Month
Due to Lobar Pneumonia	Jan. 1947
Due to	
Other conditions Gangrene Right Leg	One Week

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul M Wilson, M.D. M. D. or other

Address: Piedmont, W. Va. Date signed: Mar. 4, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

1-35

Within corporate limits

Dr. M E B C 02365

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 92d

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 years

Hospital, institution, or street address where death occurred:

1101 Anderson Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1101 Anderson Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ANNA MARY GASENHAUSE LUECK

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Frank J. Lueck

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): September 9, 1872

8. AGE: Years	Months	Days	If less than one day
74	7	22	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Henry Gasenhause

13. Birthplace: Germany

MOTHER — 14. Maiden name: Anna Miller

15. Birthplace: Cumberland, Maryland.

16. Informant: Ann Lueck

Address: 1101 Anderson St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 April 1947 (month) (day) (year)

Cemetery or crematory: St. Peter's & Paul's Cemetery

Location: Cumberland, Maryland.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland.

19. April 1, 1947 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31, 1947 19.... at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1947, to March 31 1947

and that I last saw h... alive on March 31 1947

Immediate cause of death: Cerebral Vascular hemorrhage

Due to: Myocarditis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION
3 yrs.
4 yrs.

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. E. Blevens M. D. M. D. or other

Address: 133 Virginia Ave. Date signed: 3/3/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

02366

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191-a)

CERTIFICATE OF DEATH

Dr Raymond Reeves

Reg. Dist. No. 60

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 years

Hospital, institution, or street address where death occurred:
Latrobe St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Latrobe St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Annie Thomas Malcolm

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William Malcolm

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): Feb 21, 1866

8. AGE: Years	Months	Days	If less than one day
81	1	6	...hrs. ...min.

9. Birthplace: Barton, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: own home

FATHER
12. Name: Henry Thomas
13. Birthplace: England

MOTHER
14. Maiden name: Mary Buckel
15. Birthplace: England

16. Informant: Kenneth Malcolm
Address: Westernport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 30, 1947 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cemetery

Location: Moscow, Maryland

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. March 30 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1947, at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/20/47 1947, to 3/27 1947 and that I last saw h... alive on 3/27 1947

Immediate cause of death	DURATION
Cerebral Cardio-Vascular Renal Disease	7
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Raymond N. Reeves M.D.
M. D. or other

Address Westernport Md. Date signed 3/29/47

1-35

Within corporate limits ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02367

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 1.3/4 hrs.
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? about 1.3/4hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residance of mother)
State: W.Va. County: Mineral
City or town: Wiley Ford
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Linda Ray Malone

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 10, 1947

8. AGE: Years: 0 | Months: 2 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER 12. Name: Donald A. Malone
13. Birthplace: Cumberland, Md

MOTHER 14. Maiden name: Margaret Williams
15. Birthplace: Broadtop, Pa.

16. Informant: Donald A. Malone
Address: Wiley Ford, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 26, 1947 (month) (day) (year)
Cemetery or crematory: Ft. Ashby Cemetery
Location: Ft. Ashby, W.Va.

18. Funeral director: John F. Hoffman
Address: Cumberland, Md.

19. March 25 19 47 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 19 47 at 7.55A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw her alive on March 19 47

Immediate cause of death: Broncho Pneumonia — DURATION: about 3 days
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V. Deming M.D. M. D. or other
Address: Cumberland, Md Date signed: 3-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Within corporate limits

02368

Murray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

106a

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address (where death occurred): 531 Henderson Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 531 Henderson Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Joseph Matt

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Barbara Miller Matt

6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1865

8. AGE: Years	Months	Days	If less than one day
82	2	8	...hrs. ...min.

9. Birthplace Cumberland, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Clothing Store Employee

FATHER 12. Name John Matt

13. Birthplace Germany

MOTHER 14. Maiden name Caroline Zapf.

15. Birthplace Germady

16. Informant Mrs. James Morris

Address 320 Holland St - Cumb. Md

17. Burial Date thereof Apr 2, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Peter + Pauls Cemetery

Location Cumberland Md

18. Funeral director John J. Hafer

Address Cumberland Md

19. April 1, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 1947 to March 30 1947

and that I last saw h... alive on March 30 1947

Immediate cause of death	DURATION
Heart Failure	8 hrs
Due to Acute Bronchitis	1 week
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. A. Hunter M.D.
M. D. or other

Address Cumberland Md Date signed April 1 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

02369

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Pekin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 yrs 9 mos 13 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Pekin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Michael Francis McCabe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 29 1900

8. AGE: Years	Months	Days	If less than one day
46	9	13	...hrs. ...min.

9. Birthplace: Pekin, Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: —

FATHER
12. Name: Michael McCabe
13. Birthplace: Pekin

MOTHER
14. Maiden name: Mary Martin
15. Birthplace: Lonaconing Md

16. Informant: Mrs. Michael McCabe
Address: Pekin, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 15 1947 (day) (year)
Cemetery or crematory: St. Gabriel's Cemetery
Location: Barton, Md.

18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.

19. March 13 1947 (Date rec'd by registrar) Jeannette M. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 12, 1947, at 3 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1947, to Mar 12 1947
and that I last saw him alive on March 11 1947

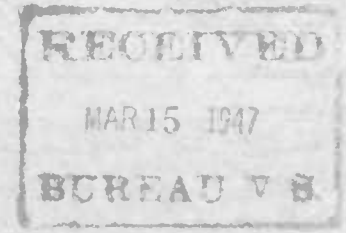
Immediate cause of death	DURATION
Coronary arterial Bronchial Asthma	
Due to	
Due to	
Other conditions	

(Includes pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry W. Hodgson M D
M. D. or other
Address: Lonaconing, Md. Date signed: Mch 13 47



1-35

08378

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Miners Hospital

How long in hospital or Institution? 2 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Amos McKenzie

3.(b) Social Security Number 218-10-4307

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Rosetta McKenzie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 27, 1875

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
71	11	7		

9. Birthplace: Garrett Cty., Md
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: Hotel

FATHER 12. Name: Francis McKenzie

13. Birthplace: Garrett County, Md.

MOTHER 14. Maiden name: Sarah Garlitz

15. Birthplace: Garrett County, Md.

16. Informant: George Griffith

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 10 1947 (month) (day) (year)

Cemetery or crematory: St. Michael's

Location: Frostburg Md

18. Funeral director: J. R. Durst

Address: Frostburg Md

19. 3-8 1947 (Date rec'd by registrar) Mrs. Nancy V. Poe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1947 at 12:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 1947 to March 7 1947 and that I last saw h[illegible] alive on March 7 1947.

Immediate cause of death	DURATION
Chronic myocarditis	
Due to Pleurisy c effusion (rt.)	2 wks.
Due to arterio-sclerosis	—
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: X Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Diehl, M.D.
M. D. or other

Address Frostburg Md Date signed 3/8/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

02371

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegheny

City or town: Lonaconing, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred:
Hodgson Maternity Clinic

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegheny

City or town: Gilmore, Near Midland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Near Midland
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Ria Marie McKenzie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 16, 1947

8. AGE: Years	Months	Days	If less than one day
2 days			..... hrs. ..... min.

9. Birthplace: Lonaconing, Allegheny County, Md.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Elmer Arthur McKenzie
13. Birthplace: Charlestown, Lonaconing, Md.

MOTHER
14. Maiden name: Mary Blubaugh
15. Birthplace: Gilmore, Md.

16. Informant: Mrs. Elmer McKenzie
Address: Gilmore, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 18 47 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md

18. Funeral director: M. Eckhart

Address: Lonaconing Md

19. 3/19 (Date rec'd by registrar) 1947 Jeanette M Boat Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 1947, at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1947, to March 18 1947

and that I last saw her alive on March 17 1947

Immediate cause of death (Enter one cause per line for (a), (b), and (c).)	DURATION
(a) premature birth (1 month)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other

Address: Lonaconing, Md. Date signed: Mch. 19 '47

1-35

02372
Dr Walton

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (99-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Mmrs Hospital
How long in hospital or Institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Depot road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Samuel G. McKenzie

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 3 - 1877

8. AGE: Years	Months	Days	If less than one day
69	4	2	hrs. min.

9. Birthplace: Garrett Co. Md.
(Town, county, and state)
10. Usual occupation: woodsman
11. Industry or business
FATHER 12. Name: John McKenzie
13. Birthplace: Pa.
MOTHER 14. Maiden name: Sarah E. Christian
15. Birthplace: Mo.
16. Informant: Mrs Allen Bolyn
Address: Frostburg, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 8 - 1947 (month) (day) (year)
Cemetery or ~~crematory~~: St. Anns
Location: Cavilton, Md.
18. Funeral director: J. J. Durst
Address: Frostburg, Md.
19. 3-7 19 47 Mrs Nancy N Rae
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 19 47 at 6 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6 19 47, to March 5 19 47
and that I last saw him alive on March 5 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 6 47
Due to Hypertensive Heart Disease	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hilda Jane Walter M.D.
M. D. or other
Address: Frostburg Date signed: 3/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8-a)

CERTIFICATE OF DEATH

★ 02373

Reg. Dist. No. 40

1. PLACE OF DEATH

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No.: — (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Nellie Irene Cunningham McKinney

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edward B. McKinney

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Feb 21, 1896

8. AGE: Years: 51 Months: 1 Days: 1 If less than one day: ____ hrs. ____ min.

9. Birthplace: Elk Garden, W. Va. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER — 12. Name: William Cunningham

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Emma A.

MOTHER — 15. Birthplace: W. Va.

16. Informant: Mrs. Edward McKinney

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 24 1947 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Westernport, Md.

18. Funeral director: H. E. Fahrney

Address: Lonaconing, Md.

19. March 24 1947 (Date rec'd by registrar) Joseph C. Jenkins M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1947 at 2 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 15 1947 to Mar 22 1947 and that I last saw h[illegible] alive on Mar 21 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 week
Due to: arterial Hypertension ?	
Due to:	
Other conditions: arteriosclerosis ?	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: N. Alfred Van Ocos M. D. or other

Address: 110 S. Center St Date signed: 24 Mar 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

Within corporate limits

Durett.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 02374

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 2 Glenwood St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 Glenwood St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs Mary Daisy McMillan

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Wm Gibbs McMillan

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Aug 31, 1904

8. AGE: Years: 42 | Months: 6 | Days: 20 | If less than one day: hrs. min.

9. Birthplace: Cumberland Allegany Co. Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER — 12. Name: Samuel T. Linn

FATHER — 13. Birthplace: Cumberland, Md.

MOTHER — 14. Maiden name: Sarah C. Abey

MOTHER — 15. Birthplace: Cumberland, Md.

16. Informant: Merritt Mc Millan

Address: 2 Glenwood St Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 24, 1947 (month) (day) (year)

Cemetery or crematory: Abe Cemetary

Location: ~~Cumberland~~ Fort Ashby, W. Va.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. March 24, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 1947 at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 21, 1947 to March 24, 1947

and that I last saw her alive on March 21, 1947

	DURATION
Immediate cause of death: Uraemia	?
Due to: Chronic Nephrosclerosis	?
Due to: Hypo-Thyrondism-Acquired	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas. R. Jones M. D. or other

Address: Cumberland. Date signed: 3/24/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-0)

CERTIFICATE OF DEATH

Reg. Dist. No. 02798 48

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 Years 10 Days

Hospital, Institution, or street address where death occurred:
209 Independence St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 209 Independence St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Eva Frances Meders

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

5.(b) Name of husband or wife: John T. Meders

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 8 1867

8. AGE: Years	Months	Days	If less than one day
80	0	10	hrs. min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: John Buchs
13. Birthplace: Germany

MOTHER
14. Maiden name: Katherine Stinebraker
15. Birthplace: Germany

16. Informant: Mrs Matilda Blaul

Address: 209 Independence St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 21, 1947 (month) (day) (year)

Cemetery or crematory: St Peter & Paul Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. March 21, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 19 47 at 2-30 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 17 19 47, to March 17 19 47 and that I last saw h[illegible] alive on March 17 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Hypertensive-Cardio Vascular Renal Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Jacob T Lees Jr MD M. D. or other

Address: 108 Va Ave Date signed: 3/19/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02375

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: Allegany Co Infirmary
How long in hospital or institution? 3 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 128 Hanover St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma Christine Metzger

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles Metzger
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 17, 1877

8. AGE: Years	Months	Days	If less than one day
69	4	4	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co. Md. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: —

FATHER
12. Name: John Wichel
13. Birthplace: Cumberland Md

MOTHER
14. Maiden name: Elizabeth Schneider
15. Birthplace: Germany

16. Informant: John C. Metzger
Address: Bedford Road, Cumberland, Md

17. burial (Burial, cremation, or removal. Which?) Date thereof: Mar 24, 1947 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland, Md.
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. March 24, 1947 (Date rec'd by registrar) J. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 1947 at 2:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1947 to Mar. 21 1947 and that I last saw her alive on Mar. 18 1947

Immediate cause of death	DURATION
Arterio-Sclerotic Hypertension Disease	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other
Address: 102 S. Centre St. Date signed: 3-22-47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (836)

CERTIFICATE OF DEATH

02376

Reg. Diat. No. 90

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60
Hospital, institution, or street address where death occurred: 141 Mc Cullock St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 141 Mc Cullock St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Floyd Spriggs Middleton

3.(b) Social Security Number: 218-10-8116

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Vera Dailey Middleton
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 20 - 1871

8. AGE: Years: 75 | Months: 11 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Mt. Savage, Alleg. Md. (Town, county and state)
10. Usual occupation: Retired Bricklayer
11. Industry or business:
FATHER 12. Name: Robert Middleton
13. Birthplace: Pair Paw W. Va
MOTHER 14. Maiden name: Marie Robinson
15. Birthplace: Pair Paw W. Va
16. Informant: Raymond Middleton
Address: 141 Mc Cullock St
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-7-47 (mo.) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md.
18. Funeral director: Jacob Foster
Address: Frostburg Md.
19. 3-6 1946 (Date rec'd by registrar) Mrs. Nancy V. Poe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 1 1947, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 24, 1947, to Mar 1 1947
and that I last saw him alive on Mar 1 1947

Immediate cause of death	DURATION
Cerebral Embolism	6 Days
Due to: Arterio Sclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W M^c Lane Jr M D M. D. or other
Address: Frostburg Md Date signed: 3-3-47

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

DR. W.F. WILLIAMS

(B)-a

02377

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: WEST VIRGINIA County: Hardy
City or town: PURGITTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
MR. CHARLES MILLER

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: ETHEL BARBE
6.(c) If alive, give age: 46 years
7. Birth date of deceased (mo., day, yr.): APRIL 19, 1879

8. AGE: Years	Months	Days	If less than one day
67	11	4	hrs. min.

9. Birthplace: Unknown
(Town, county, and state)
10. Usual occupation: FARMER
11. Industry or business
FATHER 12. Name: CHARLES MILLER
13. Birthplace: VIRGINIA
MOTHER 14. Maiden name: ANNA DILLINGER
15. Birthplace: VIRGINIA
16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 26, 1947 (month) (day) (year)
Cemetery or crematory: Old Pine Church
Location: Near Purgittsville, W. Va.
18. Funeral director: P. E. THRUSH,
Address: MOOREFIELD, W.VA.
19. March 25 1947 (Date rec'd by registrar) J. L. Foutchie, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 23 19 47 at 10:40 P

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3-17- 1947 to 3-23- 1947 and that I last saw h... alive on 3-23- 1947

	DURATION
Immedi... cause of death: Pneumonia Hypostatic (Dressing)	
Due to: Renal disease Arteriosclerosis	
Due to:	
Other conditions: Thrombosis and Gangrene Rt. Leg.	
(Include pregnancy within 3 months of death)	
Major findings of operations: Entire Rt. Leg Gangrenous Date of op.	
Autopsy results: None	

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm F. Williams M. D. or Other
Address: Cumberland Date signed: 3/24/47

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02378

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, Institution, or street address where death occurred: 429 Independence St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 429 Independence St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Mary Etta Minnicks

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Chas. Minnicks

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): July 18, 1871

8. AGE:

Years	Months	Days	If less than one day
76	8	10	...hrs. ...min.

9. Birthplace: Warren Mountain Allegany Co. Md (Town, county, and state)

10. Usual occupation: House work

11. Industry or business: At Home

FATHER 12. Name: John Flabe

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Martha North

MOTHER 15. Birthplace: Unknown

16. Informant: Louis Minnicks Address 429 Independence St. Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 31, 1947 (month) (day) (year)

Cemetery or crematory: Fillcrest Cemetery

Location: Cumberland Md.

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. March 31, 19 47 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28 19 47 at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/26-47 19 to 3/28/47 19

and that I last saw h... alive on 3/28/47 19

Immediate cause of death	DURATION
Lobar Pneumonia	6 da.
Due to: Hypertension, Mitral	
Due to: Heart disease	Yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. A. Matthai M. D. or other

Address: 101 Bon Ente St Date signed: 3/31/47

Within corporate limits

Murray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02379

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, Institution, or street address where death occurred: 210 E. Kent St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegany

City or town Mt. Savage (If outside city or town limits, write RURAL and give nearest town)

Street No. Church Hill (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Louisa Mont

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: Chas. W. Mont

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 14, 1863

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
83	10	6		

9. Birthplace: Carlisle, Cumberland Co., England (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER 12. Name: James Donnelly

FATHER 13. Birthplace: Ireland

MOTHER 14. Maiden name: Mary Mc Murray

MOTHER 15. Birthplace: England

16. Informant: Mrs. Raymond Johnston

Address 409 Lehigh St Cumb. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 23, 1947 (month) (day) (year)

Cemetery or crematory: St. George Episcopal Cemetery

Location: Mt. Savage Md

18. Funeral director: John J. Baker

Address: Cumberland, Md.

19. March 22, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1947 at 9:08 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1947 to March 20 1947

aed that I last saw h alive on March 20 1947

	DURATION
Immedia cause of death: Coronary Occlusion	20 min
Due to: Hypertension Heart Disease	and Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE F. Alan G. Hennegan M. D. or other

Address Cumberland Md. Date signed March 22 47

VS A15 4-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. A. JONES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

02380

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY CUMBERLAND, MD.

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 8 days

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? about 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town FROSTBURG
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #1 (Gilmore)
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MR. JOHN T. MOORE

3.(b) Social Security Number 215-07-0372.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MARGARET (SMITH) MOORE

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., dy., yr.) DECEMBER 3 -1877

8. AGE: Years	Months	Days	If less than one day
69	3	4	...hrs. ...min.

9. Birthplace Midland, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation unemployed

11. Industry or business FRANCIS MOORE

FATHER
12. Name FRANCIS
13. Birthplace SCOTLAND

MOTHER
14. Maiden name JANE ARTHUR
15. Birthplace SCOTLAND

16. Informant Miss Hilda Moore
Address Gilmore, Frostburg, R.F.D. #1, Md.

17. Burial Date thereof Mar 9 1947
(Burial, cremation, or removal. Which?) (month) (day), (year)

Cemetery or crematory Allegany Cemetery,
Location Frostburg, Md.

18. Funeral director Ivy Eichhorn
Address Lonaconing, Md.

19. March 9, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 7, 1947 at 1;48 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...
and that I last saw him alive on Dead March 7 1947

Immediate cause of death	DURATION
Arterio sclerotic, cardio vascular, renal disease	several years
Due to (autopsy findings)	
Due to Pulmonary edema, marked cerebral edema & myocardial degeneration.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy, results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

Deputy Medical Examiner - Allegany

23. SIGNATURE H. V. Deming MD H. V. Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 3-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Within Corporate Limits

Schindler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02381

Reg. Diat. No. 40

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Street

(If outside city or town limits, write RURAL and give nearest town)

Street No. 221 Pacific St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Mayer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 14, 1947

8. AGE:

Years	Months	Days	If less than one day
0	0	10	..... hrs. ..... min.

9. Birthplace Cumberland Allegany Co Md (Town, county, and state)

10. Usual occupation Child

11. Industry or business

FATHER

12. Name Charles J. Mayer

13. Birthplace Buda Shaft Md.

MOTHER

14. Maiden name Mary Elizabeth Lytton

15. Birthplace Kayser W. Va.

16. Informant Chas J. Mayer

Address 221 Pacific St Cumb Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 25, 1947 (month) (day) (year)

Cemetery or crematory St Peter & Paul Cemetery

Location Cumberland Md.

18. Funeral director John J. Hafer

Address Cumberland Md.

19. March 25, 1947 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947, at 10: AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14 1947, to March 24 1947

and that I last saw h... alive on March 24 1947

Immediate cause of death	DURATION
Broncho-Pneumonia	2 days
Due to —	
Due to —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE B. M. Schindler M.D., M. D. or other

Address 41 Greene St Date signed March 25/1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Write in corporate limits

Schindler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (149-6)

CERTIFICATE OF DEATH

02382

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital.

How long in hospital or institution? 31 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 334 Baltimore Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Mary Elizabeth Muir

3. (b) Social Security Number 217-10-7313

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Charles Muir

6.(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) Jan 24, 1919

8. AGE:

Years	Months	Days	If less than one day
28	1	20	hrs. min.

9. Birthplace Keyser Mineral Co., W. Va.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business at Home

FATHER
12. Name Howard Lytton
13. Birthplace Elkins W. Va

MOTHER
14. Maiden name Elsie Savage
15. Birthplace Keyser W. Va

16. Informant Chas Muir

Address 334 Balto Ave - Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 17, 1947 (month) (day) (year)

Cemetery or crematory St Peters & Pauls Cemetery

Location Cumberland

18. Funeral director John T. Hafer

Address Cumberland Md.

19. March 17, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1947 to March 14 1947

and that I last saw her alive on March 14 1947

	DURATION
Immediate cause of death Congestive Heart Failure	12 hours
Due to Myocardial Insufficiency Post Partum	2 days
Due to	
Other conditions Rheumatic Heart Disease	years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Schindler M.D.
M. D., or other

Address 41 Greenway Cumberland, Md. Date signed March 17, 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
MAR 25 1947
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

02383

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
192 Rear Wineow St.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residences of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 192 Rear Wineow St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Basil Murphy

3. (b) Social Security Number: 220-10-2417

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown 1880

8. AGE: Years: 67 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany County, Md.
(Town, county, and state)
10. Usual occupation: Shop Worker
11. Industry or business: B. & O. R. R. Co.

FATHER
12. Name: Charles Murphy
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Crowfis
15. Birthplace: Ireland

16. Informant: Mr. David Murphy
Address: Rear 192 Wineow St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 28, 1947 (month) (day) (year)
Cemetery or crematory: S. S. Peter & Paul Cem.
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. March 27, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26, 1947 at 4:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2 1947, to March 26 1947
and that I last saw h... alive on March 24 1947

Immediate cause of death	DURATION
Chronic Myocarditis	2yrs
Due to Arterio Sclerosis	4 yrs.
Due to	
Other conditions Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M E Blevins M.D.
M. D. or other
Address: 133 Va ave Date signed: 3/29/47

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-20)

CERTIFICATE OF DEATH

02384

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Lutzman Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. Lutzman Drive (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Grace Kane Nicoll

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: William Nicoll

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., dey, yr.): September 9, 1872

8. AGE: Years	Months	Days	If less than one day
74	6	1	..... hrs. ..... min.

9. Birthplace: Newark N.J. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: Lyman Kane

13. Birthplace: New Jersey

MOTHER — 14. Maiden name: Anna Ward

15. Birthplace: New Jersey

16. Informant: Mr. H. W. Seymour

Address: Lutzmans Drive, Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 13, 1947 (month) (day) (year)

Cemetery or crematory: Fairmont Cemetery

Location: Newark, N.J.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. March 10, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1947, at 6:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1- 1946 to 3-10 1947 and that I last saw h... alive on 3-9 1947

Immediate cause of death	DURATION
(a) Coronary artery disease	3 yrs
Due to (b) Chronic myocarditis	6 yrs
Due to (c) Arteriosclerosis	15 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. W. Seymour M.D. M. D. or other

Address: 726 Newark Cumberland Md. Date signed: 3/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Elinor

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02385

Reg. Dist. No. 4

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, institution, or street address where death occurred:
423 Baltimore Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 423 Baltimore Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Catherine L. Norris

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Maurice F. Norris

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): June 23, 1913

8. AGE:	Years	Months	Days	If less than one day
	33	8	21	...hrs. ...min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: John T. Knippenberg
13. Birthplace: Spring Gap, Md.

MOTHER
14. Maiden name: Rose M. Kiffner
15. Birthplace: Cumberland, Md.

16. Informant: Maurice F. Norris
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 17, 1947 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md.

18. Funeral director: John T. Hoffman

Address: Cumberland, Md.

19. March 17, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14, 1947, at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1947, to March 14 1947

and that I last saw h... alive on March 14 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 Mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: H. B. Gleason M.D. M. D. or other

Address: 176 Washington Cumberland, Md. Date signed: 3/20/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02386

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 610 Hill Top Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Martin F. O'Brien

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Carey)'Brien

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 9, 1864

8. AGE: Years	Months	Days	If less than one day
82	11	21	..... hrs. ..... min.

9. Birthplace: Piedmont, W. Va. (Town, county, and state)

10. Usual occupation: Boiler Maker - Retired

11. Industry or business: B.& O. R.R. Co.

FATHER — 12. Name: John O'Brien

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Ireland

16. Informant: Mrs. Calvin Basher

Address: 610 Hill Top Dr. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 2, 1947 (month) (day) (year)

Cemetery or crematory: St. Mary's Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. April 1, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 30, 1947 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 30 1947 to March 30 1947

and that I last saw him alive on March 3 1947

Immediate cause of death	DURATION
Lobar Pneumonia	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. P. Johnson Jr. M.D. M. D. or other

Address: Cumberland Md Date signed: 4-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

Within corporate limits Dr Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-0

02387

CERTIFICATE OF DEATH

Reg. Dist. No. 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Allegany Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Rural (Fairgo) Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Albert Edward Phillips

3. (b) Social Security Number None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: None
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Mar. 30, 1946

8. AGE: Years 0 | Months 11 | Days 22 | If less than one day ... hrs. ... min.

9. Birthplace: Cumberland, Allegany Maryland (Town, county, and state)
10. Usual occupation: Infant
11. Industry or business

FATHER
12. Name: Jerome Phillips
13. Birthplace: Swanton, Md.

MOTHER
14. Maiden name: Marie Miller
15. Birthplace: Bedford Valley, Penna.

16. Informant: Jerome Phillips
Address: Fairgo, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 25, 1947 (month) (day) (year)
Cemetery or crematory: P.O.S. of A. Cem.
Location: Centreville, Penna.

18. Funeral director: H. Wayne George
Address: Cumberland, Md.

19. March 24, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 22, 1947 at 8:10P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-17 1947, to 3-22 1947
and that I last saw him alive on 3-22 1947

Immediate cause of death: Bronchopneumonia — DURATION 10 days
Due to: Influenza
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Saville G. Weisman M.D. (M. D. or other)
Address Cresaptown, Md. Date signed 3-24-47

SGW

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2) CB

CERTIFICATE OF DEATH

★ 02388

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 415 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 Hr. 45 Min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pennsylvania County FULTON

City or town Near HANCOCK Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #1
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Virginia BRENDA ANN RITZ

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 4, 1946

8. AGE: Years	Months	Days	If less than one day
	8	2	hrs. min.

9. Birthplace MARYLAND, Cumberland, Alleg. Co
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name RALPH G. RITZ

13. Birthplace PA. Buck Valley

MOTHER 14. Maiden name THELMA MAY

15. Birthplace Near Little Orleans, Md.

16. Informant Ralph G Ritz

Address R.F.D. #1 - Hancock, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 8, 1947 (month) (day) (year)

Cemetery or crematory Buck Valley Cem

Location Buck Valley, Penna

18. Funeral director Chas East

Address Hancock Md.

19. March 6, 1947 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947, at 12:45 PM

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from March 6 1947, to March 6 1947 and that I last saw h[illegible] alive on March 6 1947

Immediate cause of death	DURATION
Pulmonary Asthma	2 days
Due to Endocarditis Ulcerative	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. G. Owens M.D. M. D. or other

Address Pleasantland Md. Date signed March 6-47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

02389

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Maryland Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: 48 Mechanic St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 48 Mechanic St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William Rizer

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Sarah Rizer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 25 1865

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
81	6	19		

9. Birthplace: Frostburg Allegany Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Brickyard

FATHER
12. Name: Simone Rizer
13. Birthplace: unknown

MOTHER
14. Maiden name: Henrietta Holtzman
15. Birthplace: Unknown

16. Informant: Mrs. Walter Rizer
Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 19 1947 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md.
18. Funeral director: J. R. Durst
Address: Frostburg Md.

19. 3-20 1947 (Date rec'd by registrar) Mrs Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 17 1947, at 6 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 22 1947, to Mar 17 1947
and that I last saw h... alive on Feb 28 1947

	DURATION
Immediate cause of death: Chr. myocarditis	4 years
arterio Sclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W O M Lane Jr M D
M. D. or other
Address: Frostburg Md Date signed Mar 18 1947

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

02390

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 Years

Hospital, institution, or street address where death occurred:
1340 Shades Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1340 Shades Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mattie Dallas Robertson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William Francis Robertson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 22 1878

8. AGE: Years	Months	Days	If less than one day
68	3	23	..... hrs. ..... min.

9. Birthplace: Flintstone, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: John B. Banks
13. Birthplace: Flintstone, Md.

MOTHER
14. Maiden name: Mary Jane Kline
15. Birthplace: Flintstone, Md.

16. Informant: Mrs Ora Mae Lewis
Address: 1340 Shades Lane, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/19/47 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. March 19 1947 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 1947, at 1:30 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 1944, to March 15 1947 and that I last saw h[illegible] alive on March 15 1947

Immediate cause of death	DURATION
a Apoplexy	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: T Bailey Hunter MD M. D. or other

Address: Cumberland Md Date signed: 3/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02391

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred: 125 N. Centre Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: 125 Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 125 N. Centre St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sara Paterson Roemer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Chas Roemer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 28, 1867

8. AGE:	Years	Months	Days	If less than one day
	79	10	22	..... hrs. ..... min.

9. Birthplace: Wheeling, West Va. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: —

FATHER
12. Name: Andrew Sweeney
13. Birthplace: West Va.

MOTHER
14. Maiden name: Marie Hanna
15. Birthplace: West Va.

16. Informant: Andrew Sweeney Roemer
Address: 125 N. Centre St. Cumberland Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Mar 24 1947 (month) (day) (year)
Cemetery or crematory: Greenmount Cemetery
Location: Wheeling, West Virginia

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. March 21, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20 1947, at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1947, to March 20, 1947, and that I last saw h.. alive on March 19, 1947. Immediate cause of death: Coronary Thrombosis — DURATION: months

Due to: Hypertension & C.V. Renal — years

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B. M. Schneider M.D. M.D. or other
Address: 41 Seventh Date signed: March 20 1947

1-35

Mr Schneider

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122a)

CERTIFICATE OF DEATH

Reg. Diat. No. 02792

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Eckhart Mines
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Ruzycki

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
70?			hrs. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual occupation Retired Miner

11. Industry or business Coal Miner

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant Mrs. Joseph McGowan

Address Eckhart Mines, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 18 1947 (month) (day) (year)

Cemetery or crematory St. Michaels

Location Frostburg, Md.

18. Funeral director Jacob Hafer

Address 23 East Main Street Frostburg, Md.

19. March 18, 19 47 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19, to 19
and that I last saw h alive on 19

Immediate cause of death Strangulated Hernia — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Strangulated Hernia Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John K. Ruzycki M.D.
M. D. or other

Address Cumberland Md. Date signed 3/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

02393

Reg. Dist. No. 4 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 303 Harrison St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 303 Harrison Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Kate Lupton Schaffer

3.(b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Oliver H. Schaffer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 26 1862

8. AGE: Years 85 Months 7 Days 3 If less than one day ..... hrs. ..... min.

9. Birthplace: Romney W. Va.

(Town, county and state)

10. Usual occupation: Housewife

11. Industry or business: Own

FATHER 12. Name: Samuel R. Lupton

13. Birthplace: Virginia

MOTHER 14. Maiden name: - Shobe

15. Birthplace: Virginia.

16. Informant: George E. Schaeffer

Address: 303 Harrison St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 31 March 1947 (month) (day) (year)

Cemetery or crematory: Indian Mound Cemetery

Location: Romney, West Virginia.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland.

19 March 31, 19 47 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 29 19 47, at 4 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 19 47, to March 29 19 47

and that I last saw h.. alive on March 29, 47 19

	DURATION
Immediate cause of death: Chronic Myocarditis	
Due to: Bronchial Asthma.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. Allphin, M.D. M. D. or Other

Address: Cumberland, Md. Date signed 3/30/47

Dr. Fred Aird Williams

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

02394

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 years

Hospital, Institution, or street address where death occurred: R.D. No. 2 Frostburg, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. No. 2 Frostburg, Md. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George W. Shoemake

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Cora Winebrenner

6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Oct. 16 - 1879

8. AGE: Years 68 | Months 3 | Days 1 | If less than one day ... hrs. ... min.

9. Birthplace Frostburg Alleg. Md. (Town, county, and state)

10. Usual occupation Retired Miner

11. Industry or business Coal Mining

FATHER 12. Name Isaac Shoemake

13. Birthplace Richmond Va

MOTHER 14. Maiden name Sophia Yost

15. Birthplace England

16. Informant Edgar W. Shoemake

Address 229 Welsh Hill Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 20 1947 (month) (day) (year)

Cemetery or crematory Sorbis Cemetery

Location Eckhart Mines Md.

18. Funeral director Jacob Dafen

Address Frostburg, Md.

19. 3-19 1947 Mrs Nancy V. Roe Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1947 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/12 1942, to 3/17 1947

and that I last saw him alive on 3/13 1947

Immediate cause of death Cerebral hemorrhage — DURATION 24 hrs

Due to Arteriosclerosis

Due to Heart disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hilda Jane Lantry M.D. M. D. or other

Address Frostburg, Md. Date signed 3/18/47

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02395

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
249 N. Center St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 247 N. Center St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mrs. Sarah Helen Stark

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife: John Frank Stark
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1880

8. AGE: Years	Months	Days	If less than one day
~~66~~ 66	5	7	..... hrs. ..... min.

9. Birthplace: Vale Summitt, Md. (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: Frank Mc Mahan
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mc Millan
15. Birthplace: Ireland

16. Informant: Philip Stark
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 5, 47 (month) (day) (year)
Cemetery or crematory: St. ~~Peter's~~ Cem. Patricks
Location: Cumberland, Md.

18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md.

19. March 4, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 1947, 11.45P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw her alive Dead March 2 1947

Immediate cause of death	DURATION
Chronic Myocarditis	several years
Due to: arterio-sclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. (M. D. or Coroner)
Address: Cumberland Md. Date signed: 3-3-1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02396

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Luhrman (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 64 years

Hospital, institution, or street address where death occurred: Luhrman R.D. #2 Frostburg, Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Luhrman (If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. #2 Box 58 Frostburg, Md. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Hannah Evans Steele

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John T. Steele

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Feb. 17 - 1873

8. AGE:

Years	Months	Days	If less than one day
71	0	20	hrs. min.

9. Birthplace: Frost Mines Allegany, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Thos. L. Evans

FATHER — 13. Birthplace: Wales

MOTHER — 14. Maiden name: Mary Evans Lewis

MOTHER — 15. Birthplace: Wales

16. Informant: Lucile Steele

Address: R.D. #2 Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-9-1947 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg

18. Funeral director: Dwight Vaughn

Address: Frostburg Md.

19. 3-8- 1947 (Date rec'd by registrar) Mrs. Mumey H Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7 1947 at 4:04 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1947 to Mar 7 1947 and that I last saw h... alive on March 6 1947

Immediate cause of death	DURATION
Coronary Occlusion	1 day.
Due to Pleurisy.	2 days.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. E. Gatliff M.D. (M. D. or other)

Address: Frostburg, Md. Date signed: 3/9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Gattens

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

02397.

CERTIFICATE OF DEATH

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 DAYS
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITIAL
How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town WESTERNPORT
(If outside city or town limits, write RURAL and give nearest town)
Street No. 103 MAIN STREET
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME CARRIE STOLL

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife WILLIAM [redacted] F. Stoll
6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) JULY 23, 1877

8. AGE: Years 69 Months 8 Days 6 If less than one day ..... hrs. ..... min.

9. Birthplace [redacted] York Haven, Penna.
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name MEARS, JAMES
13. Birthplace Unknown

MOTHER 14. Maiden name SMITH, ISABELLA
15. Birthplace Unknown

16. Informant Meredith Stoll
Address Wilmington, Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1, 1947 (month) (day) (year)
Cemetery or crematory Silver Brook Cem.
Location Wilmington, Delaware

18. Funeral director E. Edwards & Son
Address Westernport, Md.

19. March 30, 1947 (Date rec'd by registrar) J. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1947 at 7.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Mar 1947 to 29 Mar 1947
and that I last saw h[illegible] alive on 29 Mar 47

Immediate cause of death	DURATION
(a) Bronco Nephritis (Uremia)	
Due to (b) Generalized Arteriosclerosis	
Due to	
Other conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. T. Williams M. D. or other
Address Cumberland Date signed 3/31/47

2-35

159 AND Death 3387

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILL~~BIRTH

Reg. Dist. No. 4

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Allegany (Allegheny)

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution: Decatur St

Length of mother's stay in County Life

(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland

County ~~Allegheny~~ Allegany

City or town Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If RURAL give LOCATION)

3. Name of child

4. Date of birth March 31, 1947 Hour 12:45 A.M.

5. Sex Male | 6. Twin or triplet ----

7. No. of weeks pregnancy 4 1/2 mos.

FATHER OF CHILD

8. Full name Ray Elwood Stouffer

9. Color white 10. Age at time of this birth 29 yrs.

11. Usual occupation spinner, celanese corp. of America

MOTHER OF CHILD

12. Full maiden name Mary Elizabeth Witt

13. Color White 14. Age at time of this birth 25 yrs.

15. Usual occupation Mt. Savage, Md. - hswf.

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 2

(b) How many other children were born alive but are now dead? 2 (c) How many other children were *born* dead? 0

17. Did child die before labor? no During labor? no

18. Pregnancy, complications of Septic Stillbirth and Premature Birth

19. Labor: (a) Complications of no

(b) Induced? no

20. (a) Was there an operation for delivery? no (Yes or No)

(b) State all operations, if any

(c) Did child die before operation?

During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Not known

(b) Maternal causes Stillbirth and Premature Birth

22. I certify to the birth of this child who was born dead* on the date and hour above stated. April 2-47

Signature [illegible] M.D.

(Specify if M. D., midwife, or other)

Address [illegible] Cumberland Md

23. (a) (Burial, cremation or removal) (b) Date thereof March 31-47 (month) (day) (year)

(c) ~~Cemetery or~~ crematory

24. (a) Funeral director [illegible]

(b) Address

25. (a) (Date rec'd by registrar) (b) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

V. S. A10

Baby expired 2 h. & 45 m. after birth

Within corporate limits

02398

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 13 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rt. 6. (Potomac Park)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Near Cumberland, Rural

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Howard O. Strawser

3.(b) Social Security Number: 214-07-1945

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Florence Heckert

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 4, 1892

8. AGE: Years	Months	Days	If less than one day
55	0	1	..... hrs. ..... min.

9. Birthplace: Eglon, Tucker, W. Va. (Town, county, and state)

10. Usual occupation: Foreman

11. Industry or business: Celanese Corp. of America

FATHER 12. Name: Joseph Strawser

FATHER 13. Birthplace: Jane Lou, W. Va.

MOTHER 14. Maiden name: Emma Parks

MOTHER 15. Birthplace: Masontown, W. Va.

16. Informant: Willard F. Strawser

Address: Rt. 6. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/8/47 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19 March 8 19 47 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 19 47 at 8-55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4 19 46 to March 5 19 47

and that I last saw h[illegible] alive on March 5 19 47

Immediate cause of death	DURATION
miliary tuberculosis	6 weeks
Due to pulmonary tb	6 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M.D. (M.D. or other)

Address: 58 Greene St. Date signed 3-6-47

Within corporate limits

Dr. Schindler

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d) CP

CERTIFICATE OF DEATH

02399

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

I

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 day

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: W. Va. County: Mineral

City or town: Ridgeley (If outside city or town limits, write RURAL and give nearest town)

Street No. 148 Main St (If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American War

3.(a) FULL NAME: James Reese Swaner

3.(b) Social Security Number: 705-10-8377

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Alice Edith VanMeter Swaner

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): February 14, 1872

8. AGE: Years 75, Months 0, Days 25. If less than one day ....hrs. ....min.

9. Birthplace: Keyser, W. Va. (Town, county, and state)

10. Usual occupation: Carmen's helper

11. Industry or business: W. M. R. R.

FATHER 12. Name / 13. Birthplace: Unknown

MOTHER 14. Maiden name / 15. Birthplace

16. Informant: Elton J. Weakley

Address: 148 Main St. Ridgeley, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 11, 1947 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. March 11, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9, 1947, at 1:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1947, to March 9, 1947, and that I last saw him alive on March 9, 1947

Immediate cause of death: Auricular Fibrillation — DURATION: 1 week

Due to: Hypertensive C. V. Disease — DURATION: Years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations .... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury .... Injured at work?

23. SIGNATURE: B. M. Schindler MD. M. D. or other

Address: 41 Greene St. Date signed: Mar 11/47

2-35

Within corporate limits of Cumberland

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02400

Reg. Diat. No. 40

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
451 Henderson Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 451 Henderson Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Bridget Anne Trenent

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Trenent

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr. 3, 1881

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
65	11	19		

9. Birthplace: Wheeling, W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Corrigan

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: ---------- Filbin

MOTHER — 15. Birthplace: Ireland

16. Informant: Mrs. Catherine Welton

Address: 451 Henderson Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 26, 1947 (month) (day) (year)

Cemetery or crematory: HillCrest Burial Park

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. March 25 19 47 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 22, 19 47 at 10:A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 20 47 19 to Mar 22 19 47 and that I last saw h[illegible] alive on 3/22/47 19

Immediate cause of death	DURATION
Chr. Myocarditis	
Due to Bronchial Asthma	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (562)

CERTIFICATE OF DEATH

02401

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 7 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Columbia St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah Jane Turley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B.(b) Name of husband or wife: Harry Turley

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 10, 1877

8. AGE: Years	Months	Days	If less than one day
69	5	23	____ hrs. ____ min.

9. Birthplace: Straffordshire, England
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Samuel Snelson
13. Birthplace: England

MOTHER
14. Maiden name: Harriet ----------.
15. Birthplace: England

16. Informant: Mr. Harry Turley
Address: Columbia St. Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 6, 1947 (month) (day) (year)

Cemetery or crematory: St. George Episcopal

Location: Mt. Savage, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. March 5 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3, 1947, at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 23 1947, to March 3 1947, and that I last saw h[illegible] alive on March 2 1947.

	DURATION
Immediate cause of death: Septic Infection	1 week
Due to: Ulcerated [illegible] not due to cancer	[illegible] week
Due to: Hemorrhage, cerv. uterus	2 wks
Due to: Senile Anemia	[illegible] week
Due to: Due to Polyp just in colon.	
Other conditions: Hemorrhage	
Disease	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: F. Allen G. Murray M.D. M. D. or other

Address: Cumberland Md. Date signed: March 5/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

02402

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 16 Klostermans Addition

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth M. Turner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Barthomelow Turner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 1, 1872

8. AGE: Years	Months	Days	If less than one day
74	5	4	..... hrs. ..... min.

9. Birthplace: Philadelphia, Penna. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Henry Hannigan

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Mary Gilsten

MOTHER — 15. Birthplace: Scotland

16. Informant: Mr. Joseph P. Turner

Address: 16 Klostermans Addt. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 8, 1947 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: Philadelphia, Penna.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. March 5 19 47 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 19 47, at 1 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/27/47 19 to 3/5/47 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Uremia Carcinoma of cervix	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John M. Lozupone M D M. D. or other

Address: Cumberland Md Date signed: 3/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

02403

Reg. Diat. No. 40

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 days

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 71 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town MIDLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME MRS. EMMA WAGUS

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife EDWARD WAGUS

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-29-79

8. AGE:

Years	Months	Days	If less than one day
67	11	13	...hrs. ...min.

8. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation Housework

11. Industry or business own home

FATHER — 12. Name PARKER

FATHER — 13. Birthplace MARYLAND

MOTHER — 14. Maiden name PENDEGRASS

MOTHER — 15. Birthplace MD.

16. Informant Mrs. Mary Crowe

Address Midland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 15 1947 (month) (day) (year)

Cemetery or crematory allegany Cemetery

Location Frostburg, Md.

18. Funeral director M. Eichhorn

Address Lonaconing, Md.

19. March 15, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1947, at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12.31.1946 to 3.12.1947 and that I last saw h[er] alive on 3.12.1947

Immediate cause of death	DURATION
Bronchopneumonia	
Due to	3 days
Due to	
Other conditions Cor Hypertrophic Arthritis	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. F. Williams M. D. or other

Address Cumberland Date signed 3/13/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

Within corporate limits

Dr. E. Brn 3404

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Route 4, North Branch
(If outside city or town limits, write RURAL and give nearest town)
Street No. Cumberland, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: BETTIE SUE WHARTON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4 May 1944

8. AGE:	Years	Months	Days	If less than one day
	2	10	8	hrs. min.

9. Birthplace: North Branch, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: Charles Wharton
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sylvia Royer
15. Birthplace: Maryland

16. Informant: Charles Wharton
Address: Route 4, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 15 1947 (month) (day) (year)
Cemetery or crematory: Fort Ashby Cemetery
Location: Fort Ashby, W.Va.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19 March 14 19 47 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 March 19 47 at 6:45 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 11 19 47 to March 12 19 47
and that I last saw her alive on March 11 19 47

Immediate cause of death	DURATION
septicemia	
Due to: lobar pulmonia r upper lobe	5 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: lobar pulmonia, septicemia
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Elizabeth Group M.D. M. D. or other
Address: Loup Md. Date signed: 3/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02405

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 2 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: W. Va. County: Mineral

City or town: Keyser

(If outside city or town limits, write RURAL and give nearest town)

Street No. 528 Newton St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Katherine Mabel Whetzel

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 10, 1947

8. AGE:

Years	Months	Days	If less than one day
0	0	2	..... hrs. ..... min.

9. Birthplace: Cumberland Md.

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER

12. Name: Paul Whetzel

13. Birthplace: Petersburg, W. Va.

MOTHER

14. Maiden name: Madeline Bradford

15. Birthplace: Moorefield, W. Va.

16. Informant: Mrs. Paul Whetzel

Address: Keyser, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 13, 1947 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. March 13, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12, 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 mn, 1947, to 12 mn, 1947

and that I last saw h[illegible] alive on 11 mn, 1947

Immediate cause of death	DURATION
Prematurity.	
Due to	
Due to	
Other conditions: Hemmorrhagin Pneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Fuller B. Hunt M. D. or other

Address: 112 Bedford St. Date signed: 12 mn 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 4-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-C

CERTIFICATE OF DEATH

02406

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 15 minutes

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? about 15 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No. 182 W. Main St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Clarence Edward Whitacre

3.(b) Social Security Number: 214-16-2037

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife: Eva Blocher

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. Ist., I878

8. AGE: Years	Months	Days	If less than one day
68	2	2I	..... hrs. ..... min.

9. Birthplace: Peach Bottom, Pa. (Town, county, and state)

10. Usual occupation: Butcher

11. Industry or business:

FATHER 12. Name: George Whitaker

13. Birthplace: Unknown

MOTHER 14. Maiden name: Lacey Ann

15. Birthplace: Unknown

16. Informant: Miss Edna Whitaker

Address: I82 W. Main St., Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 25th., '47 (month) (day) (year)

Cemetery or crematory: Johnsons Cemetery

Location: Route 40 Highway, Frostburg, Md.

18. Funeral director: Jacob Hafer

Address: Frostburg, Md.

19. 3-24 19 47 (Date rec'd by registrar) Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 19 47, at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on March 22 19 47

Immediate cause of death: Fracture of the 3rd. cervical vertebrae, linear fracture of skull & concussion of brain — DURATION: about half hour

Due to:

Due to: Hit by an automobile

Other conditions: Fractures of nose, left leg above ankle & right femur

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 3.22.1947

Where did injury occur? near Frostburg (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?): about 1/8 mi. north of R.F.D. 40 Frostburg

Means of injury: Auto. skidded on snow Injured at work? going to

Deputy Medical Examiner - Allegany

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. (M. D. or other)

Address: Cumberland Md Date signed: 3-22-1947

I-35

Within corporate limits

02407

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 40

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 Months
Hospital, institution, or street address where death occurred:
Allegany Hosp,
How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 213 S. Spruce St.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SANDRA KAY WILKINSON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1945

8. AGE: Years	Months	Days	If less than one day
1	5	28	hrs. min.

9. Birthplace: Cumberland Allegany Maryland
(Town, county, and state)
10. Usual occupation: Infant
11. Industry or business

FATHER
12. Name: Ralph E. Wilkinson
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Thelma V. Hall
15. Birthplace: Culpepper, [illegible] Va.

16. Informant: Mr. Ralph E. Wilkinson
Address: 213 S. Spruce St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 25, 1947 (month) (day) (year)
Cemetery or crematory: Hill Crest Cem.
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. March 24, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 22, 1947 at 1:00P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21, 1947, to March 22, 1947
and that I last saw h[illegible] alive on March 22, 1947

Immediate cause of death	DURATION
Acute Myocarditis	2 dys
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. P. Johnson M.D. M. D. or other
Address: Cumberland Md. Date signed: 3-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Within corporate limits ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

02408

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs.

Hospital, Institution, or street address where death occurred: 328 Fayette St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 328 Fayette St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Miss Emma Willison

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife: ———

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan 19 1861

8. AGE: Years 86 Months 7 Days 6 If less than one day: ____ hrs. ____ min.

9. Birthplace: Lancaster County, Virginia
(Town, county, and state)

10. Usual occupation: NONE

11. Industry or business:

FATHER 12. Name: Asabel Willison

13. Birthplace: Scotland

MOTHER 14. Maiden name: Amanda Bryan

15. Birthplace: Scotland

16. Informant: J. J. Robinson

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 27 47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. March 27, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 19 47, at about 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw her alive on March 25 19 47

Immediate cause of death	DURATION
Chronic Myocarditis	several years
Due to:	
Due to:	
Other conditions: Arterio sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H. V. Deming M.D. H V Deming MD (M. D. or other)

Address: 125 Bedford St Cumberland Md Date signed: 3-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-6)

CERTIFICATE OF DEATH

02409

Reg. Dist. No. 60

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 Years

Hospital, institution, or street address where death occurred: Green St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Green St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Daniel Floyd Wilt

3.(b) Social Security Number: 220-10-2696

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Aldie Mae Wilt

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Nov 19, 1881

8. AGE: Years	Months	Days	If less than one day
65	4	0	...hrs. ...min.

9. Birthplace: Frankville, Garrett, Maryland (Town, county, and state)

10. Usual occupation: Watchman

11. Industry or business: WPA

FATHER — 12. Name: John F. Wilt

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sarah Ellen Wilt

MOTHER — 15. Birthplace: Maryland

16. Informant: Minnie Wilt

Address: Westernport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 23, 1947 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Maryland

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. Mar 22 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19, 1947, at 5:45p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12, 1947, to March 19, 1947 and that I last saw him alive on March 19, 1947

Immediate cause of death	DURATION
Cerebral Thrombosis	5 days.
Due to: Cerebral Arteriosclerosis	
Due to:	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Herman Reece M.D. M. D. or other

Address: Westernport md Date signed: 3-22-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

Within corporate limits

02410

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 wks.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Eckhart Mines

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. D. No 1 Frostburg

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Louisa S. Wright

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Edward W. Wright

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 13 - 1885

8. AGE: Years	Months	Days	If less than one day
61	8	28	..... hrs. ..... min.

9. Birthplace Six Mile Run, Alleg. Md. (Town, county, and state)

10. Usual occupation Nurse maid

11. Industry or business

FATHER 12. Name John Starling

13. Birthplace Va.

MOTHER 14. Maiden name Margaret Bluefang

15. Birthplace Loud Mt. Md.

16. Informant Edward E. Wright

Address R. D. #1, Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-13-1947 (month) (day) (year)

Cemetery or crematory Eckhart Cemetery

Location Eckhart, Md.

18. Funeral director Jacob Yaste

Address Frostburg, Md.

19 March 13 19 47 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 March, 19 47 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 February 19 47, to 11 March 19 47

and that I last saw her alive on 11 March 19 47

Immediate cause of death	DURATION
Chronic nephritis with terminal uremia.	
Due to Chronic choleystitis	3 mos.
Due to Chronic Hepatitis	3 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Chronically diseased gall bladder and liver. Date of op. 7 Mar. 1947

Autopsy results No autopsy.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. Alfred Van Demark, M.D. M. D. or other

Address 110 S. Centre St. Date signed 13 March 1947

2-35

Within corporate limits

Durett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93a

CERTIFICATE OF DEATH

02411

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 320 Baltimore Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 320 Baltimore Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Sarah Virginia Wright

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Luther E. Wright
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 20, 1857

8. AGE:

Years	Months	Days	If less than one day
89	11	10	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co., Md
(Town, county, and state)
10. Usual occupation: House Work
11. Industry or business: at Home

FATHER
12. Name: Samuel Piper
13. Birthplace: Unknown

MOTHER
14. Maiden name:
15. Birthplace:

16. Informant: Miss Grace Wright
Address: 320 Baltimore Ave., City

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 4, 1947 (month) (day), (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md.

18. Funeral director: John J. Hafer
Address: Cumberland, Md.

19. April 1, 1947 (Date rec'd by registrar) J. P. Franchi M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 19 47 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15. 19 47, to Mar. 30 19 47
and that I last saw h[illegible] alive on Mar. 28. 1947

Immediate cause of death	DURATION
Pneumonia	4 wks
Due to: Hypostatic	4 wks
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clark L. Jones M.D. or other
Address: Cumberland Date signed: 3/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M